STATE OF GEORGIA

OFFICE OF THE GOVERNOR

ATLANTA 30334-0900

Zell Miller
GOVERNOR

May 28,1998

The Honorable Donna E. Shalala
Department of Health and Human Services
200 Independent Avenue, Southwest
Washington, D.C. 20201

Dear Secretary Shalala:

I am pleased to submit Georgia's state plan for implementing Title XXI of the Social Security Act. Healthy children, ready to learn and to take advantage of the educational opportunities offered in Georgia have been one of my long-standing objectives.

After much public input and debate, Georgia has elected to establish health care coverage for uninsured, low income children that is built on certain principles held by Georgia citizens. The Georgia Child Health Insurance Program (CHIP) will provide health care benefits for uninsured children from birth through 18 years of age in families with income below 200 percent of the federal poverty level who are not eligible for Medicaid and have no other health care coverage. Georgia's program is not an expansion of Medicaid nor is it an entitlement. However, Georgia's plan will offer substantially the same health care services available to children under our Medicaid plan.

Fran Ellington, Director of Medicaid Eligibility and Quality Control, Department of Medical Assistance, will serve as our contact for HCFA concerning the review of this plan. She may be contacted at 404/651-9981. Georgia is excited by the opportunities Title XXI offers in making health care coverage available to our uninsured children. I look forward to a prompt and positive response to our plan.

With kindest regards, I remain

Sincerely,

Zell Miller

ZM:lb
Attachment

APPLICATION FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: STATE OF GEORGIA

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

Zell Miller, Governor, State of Georgia _____ Date Signed

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuances of the Department.

Section 1. General Description and Purpose of the State Child Health Plans (Section 2101)

The state will use funds provided under Title XXI primarily for (Check appropriate box):

1.1. ☒ **Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); OR**

1.2. ☐ **Providing expanded benefits under the State's Medicaid plan (Title XIX); OR**

1.3. ☐ **A combination of both of the above.**

Introduction

The State of Georgia will implement a State Children's Health Insurance Program based on Title XXI of the Social Security Act and on legislation passed by the Georgia General Assembly in the 1998 session. The Georgia legislation, the "Peachcare for Kids Act", was passed after months of research, planning, public involvement and program design. Section 9.9 provides a detailed description of the public involvement in the design of the plan. This Title XXI State Plan describes Georgia's plan for initiating health care coverage for uninsured, low income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children and that is built on certain principles held by Georgia citizens.

The "Peachcare for Kids Act" (Attachment 1), offered by Representatives Mickey Channell and Sharon Trense, as a substitute for Senate Bill 410, authorizes the creation of the Peachcare for Kids Program, to be administered by the Department of Medical Assistance (DMA), the state agency which administers the Medicaid program. However, as DMA began working on implementation, we found that the name Peachcare Health Plan, Inc. was already reserved in Georgia. We have written to the firm with the reservation to request that the State be allowed to use the name Peachcare for Kids for Georgia's Children's Health Insurance Program (CHIP). The firm has replied that they have a pending Intent to Use Application in the federal Patent and Trademark Office for the name and mark and they are investigating the request and will give a decision shortly. In the meantime, DMA will obtain the services of a qualified marketing, advertising, public relations or graphic design firm and/or consultants to develop alternative name choices, logos and program identities that will appeal to the target populations for Georgia's ***CHIP.*** Since the issue of the official name of the program is not yet resolved, for the remainder of this State Plan, the program will be referred to as the Georgia CHIP and the Peachcare for Kids Act will be referred to as the Georgia ***CHIP*** legislation.

The legislation establishes the program to provide health care benefits for uninsured children from birth through 18 years of age in families with income below 200 percent of the federal poverty level who are not eligible for medical assistance under Medicaid. The eligibility distribution of uninsured children by age and percent of 1998 federal poverty level (FPL) for Georgia Medicaid and for Georgia CHIP is shown in the following table:

Age	100% FPL ($16,450/yr.)*	133% FPL ($21,879/yr.)*	150% FPL ($24,675/yr.)*	185% FPL ($30,433/yr.)*	200% FPL ($32,900/yr.)*
0 through 1 year	Medicaid				Georgia CHIP
1 through 5 years	Medicaid		Georgia CHIP		
6 through 18 years	Medicaid	Georgia CHIP			

*Represents annual income for a family of four.

The Georgia CHIP is not an expansion of the Medicaid program nor is it an entitlement. However, by legislation Georgia CHIP will offer substantially the same health care services available to children under Georgia's Medicaid plan. Section 6 provides a detailed description of the benchmark benefit package and additional services which will be offered. These benefits are substantially the same as those offered to children under the state Medicaid plan. The Georgia CHIP legislation does exclude nonemergency transportation and targeted case management services from the benefit package and does authorize the DMA to utilize appropriate medical management and utilization control procedures necessary to manage care effectively. The program is to operate subject to the availability of funds specifically appropriated by the General Assembly and federal funds available under Title XXI. The legislation authorizes the DMA to prospectively limit enrollment and modify the health care benefits when there is reason to believe the cost of the enrollment or services may exceed the availability of funding.

Covered health services are to be delivered through the existing Medicaid provider system. The Georgia CHIP legislation mandates that "Any health care provider who is enrolled in the Medicaid program shall be deemed to be enrolled in the program." Section 3 provides a detailed description of the current Medicaid child health assistance delivery and utilization control system, which is the proposed system for Georgia CHIP. Briefly, the current system includes a statewide primary care case management program, Georgia Better Health Care (GBHC), approved by the Health Care Financing Administration (HCFA) as a demonstration through waiver authority of section 1915(b)(1) of the Social Security Act; and a voluntary Managed Care Organization (MCO) program available in four metropolitan areas of the state. The Georgia CHIP legislation allows the DMA to contract with licensed health maintenance organizations (HMOs) or provider sponsored health care organizations (PSHCCs), but prohibits required enrollment in an HMO or PSHCC as a condition of receiving coverage under the program. This plan will give families the choice of any enrolled primary care physician or provider in the GBHC program or they may choose to enroll eligible children in any of the Medicaid MCOs that are available in their county.

Except for children under six years of age, the Georgia CHIP legislation requires payment of premiums for participation in the program. For children over 6, this plan sets extremely low

premiums of $7.50 for one child and $15.00 for a sibling group of any size. The legislation allows the DMA to set copayments except for preventive services, but this plan does not require any copayments.

Additionally, the Georgia ***CHIP*** legislation is clear that legislative intent is for reduction of barriers to application for and receipt of services under the program. DMA is directed to provide for outreach and to accept applications by mail or in person. This plan includes a large marketing and outreach component, which is described in more detail in Section 5.

The Georgia CHIP legislation embodies certain principles held by Georgia citizens. As Georgia ***CHIP*** is implemented, those guiding principles, which follow, will be observed:

- There should be less expansion of entitlements and more emphasis on personal responsibility. This option to create a separate program does not create an entitlement for the health benefits. If a future legislature decides to reduce or limit expenditures for this purpose, enrollment caps and benefit reductions can be applied.

- The process of obtaining coverage and accessing health care should not resemble a "welfare" model. If eligible fer Medicaid, many families may not accept Medicaid because they view it as "welfare". Families eligible for ***CHIP*** should be able to enroll in the Georgia ***CHIP*** program without experiencing any welfare stigma.

- Existing infrastructure that can be modified to support Georgia ***CHIP*** should be used when possible to avoid creating additional government bureaucracy. DMA is experienced in administering the Georgia Medicaid program which already provides health care benefits for over 700,000 children.

- The goal is to provide "Medicaid look-alike" coverage for the health care that all eligible children need.

- A high percentage of enrollment is desired.

- High utilization of preventive care is desired.

- The separate plan should be coordinated with public systems of care such as Medicaid, other types of health care benefits and health care services provided by the Department of Human Resources.

- The coverage should be cost effective for both the state and federal governments.

The proposed effective date for implementation of Georgia CHIP and this State Plan is September 1, 1998. The marketing and outreach effort will be rolled out for a pilot area of the state in August to begin developing public awareness prior to implementation. During the months of September and October, applications will be taken in the pilot mea. The pilot area will be large enough to test and make necessary

corrections in eligibility, enrollment, and information systems. Benefit coverage in the pilot area will begin November 1, 1998. If all systems are operating correctly, the statewide marketing and outreach campaign will begin in November 1998. Applications will be accepted statewide on December 1, 1998 for benefit coverage effective January 1, 1999.

Proposed Effective Date: 07/01/98

Section **2.** General Background and Description of State Approach to Child Health Coverage
(Section **2102 (a)(1)-(3))** and **(Section2105)(c)(7)(A)-(B))**

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section **10** for annual report requirements).

Of the 2,024,274 children in the state, Georgia estimates (using the Current Population Survey data from 1994, 1995, and 1996) that 320,243 are without any creditable coverage. Of the 1.7 million who do have creditable coverage, 759,023 (almost half) have coverage as through Georgia Medicaid. The 320,243 without coverage includes 227,603 children with income below 200% of the FPL. Of these children, 124,621 could be eligible for the existing Medicaid program. The other 102,982 are potentially eligible for Georgia ***CHIP.*** These uninsured children, whether eligible for Georgia CHIP or Medicaid, will be targeted for enrollment through the state's marketing and outreach efforts.

The estimates of children with creditable coverage in the following table are based on the Current Population Survey and are submitted as requested to allow comparisons to be made between states and on a nationwide basis. The source of the data is the Current Population Survey, combined tape 1994, 1995, 1996 (data for years 1993, 1994, 1995) as calculated by William S. Custer, Ph.D. **and** Patricia Ketsche, Center for **Risk** Management and Insurance Research, Georgia State University. The sample size for some categories is very small, and the numbers should be used with caution.

Insurance Status of Children in Georgia						
Attributes of Population	**Current Medicaid Enrollees**	**Children without Creditable Coverage***				
		Total	**Eligible for Medicaid**		**Eligible for CHIP**	
TOTAL	759,023	320,243	124,621	39%	102,982	32%
Income Level						
<100%	**	112,449	112,449	100%	***	0%
100-133%	**	47,928	7,061	15%	40,867	85%
134-185%	**	56,718	5,111	9%	51,607	91%
186-200%	0	10,508	0	0%	10,508	100%
>=200%	0	92,640	0	0%	0	0%
Age						
0 to 1	107,591	16,037	7,744	48%	***	0%
1 through 5	256,618	67,165	28,938	43%	14,901	22%
6 through 12	243,021	119,112	38,634	32%	54,199	46%
13 through 18	151,793	117,929	49,305	42%	33,882	29%
Race/Ethnicity						
Black, non-Hispanic	429,690	164,500	74,298	50%	54,455	33%
Hispanic	32,006	14,009	7,844	60%	3,113	22%
White, non-Hispanic	262,585	135,817	42,281	35%	43,619	32%
Other****	34,742	5,827	198	3%	1,795	31%
Location						
MSA	425,174	181,618	67,991	37%	53,843	30%
non-MSA	333,849	138,625	56,627	41%	49,131	35%

*The percentages of children without creditable coverage do not add to 100 because children over 200% of poverty are not included, since they are not eligible for Medicaid or for Georgia CHIP. categories

**The current Medicaid information system does not have income data on non-SSI Medicaid eligibles. However, Medicaid has no enrollees at income levels above 185% of poverty. With implementation of the SUCCESS eligibility determination system in the Division of Family and Children Services of the Department of Human Resources, income information and family size will be available.

***CPS did not identify any individuals in this cell.

****Other racial/ethnic groups cannot be reported for GA from CPS due to very small sample size.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Currently, Georgia's only public child health insurance plan is the Medicaid program administered by the Department of Medical Assistance. The Department has several approaches to identifying and enrolling eligible children. These approaches are described in the following paragraphs.

Division of Family and Children Services (DFCS)

The Department of Medicaid Assistance has an interagency agreement with the Department of Human Resources (DHR) to provide, through its Division of Family and Children Services (DFCS), Medicaid eligibility determinations for all Medicaid coverage groups other than SSI cash assistance. For pregnant women and children, these coverage groups include: Low Income Medicaid, Medically Needy, Right From the Start Medicaid (RSM - Georgia's poverty level Medicaid program), and the Katie Beckett Deeming Waiver programs. These programs are offered in conjunction with other entitlement programs and supportive services that are offered by DFCS. DFCS is also responsible for Food Stamps, Temporary Assistance for Needy Families (TANF), Child Protective Services and Foster Care. The Medicaid application process is coordinated with that for cash assistance and employment related services available through TANF. Children in families seeking these services also have their Medicaid eligibility determined. The State of Georgia has 159 counties. Each county has at least one DFCS office, and some counties have multiple sites for Medicaid eligibility intake. Some workers from these local DFCS offices are assigned to Federally Qualified Health Centers (FQHCs) and Disproportionate Share Hospitals.

While the bulk of the state's Medicaid determinations are made locally at the county DFCS offices, the RSM Outreach Project is an aggressive outreach program targeted at enrolling uninsured and underinsured poverty level pregnant women and children in Medicaid. This project operates under a separate interagency agreement between the Department of Medical Assistance and the Department of Human Resources. The eligibility workers who are part of this project are housed in locations other than the local DFCS offices. The RSM Outreach Project is described in greater detail under Section 5.1.

Public Health Departments and Federally Qualified Health Centers

DMA also coordinates Medicaid enrollment efforts with the activities of the Division of Public Health, a part of the Department of Human Resources. Across the state, perinatal case management services and the Medicaid application process are linked. At the public health departments and federally qualified health centers, a pregnant woman can apply for Presumptive Medicaid eligibility, and begin receiving prenatal services immediately. As part of this process, the pregnant woman applies for RSM Medicaid to ensure ongoing Medicaid eligibility. When the pregnant woman applies for RSM, any children in the family are also included on the application form and the form with the children's names are routed to DFCS for a determination of their eligibility along with that of the pregnant woman.

The Division of Public Health, through its local health departments, and the federally qualified health centers administer the Special Nutritional Program for Women, Infants and Children (WIC) as well. This program provides nutritious food to supplement the regular diet of pregnant women, breast-feeding women, infants, and children under age five who meet state income standards. Generally, on the initial visit to either of these facilities, the pregnant woman is certified for Presumptive Medicaid eligibility, applies for regular Medicaid for herself and her children, and receives WIC for herself and any children under the age of five *(5)*.

In both the public health departments and the federally qualified health centers, outreach workers are stationed or visit on a weekly basis to process applications for regular ongoing RSM Medicaid for pregnant women and children. In addition to Medicaid certifications, they provide information on the services covered under the program and provide information on other supportive services in the communities. When appropriate they make referrals to these services as well.

Medicaid Participating Providers

Medicaid participating providers who treat newborn children, such as family practitioners, pediatricians and hospitals, play an integral part in enrolling uninsured children in the Medicaid program. These providers have direct access to a special unit located with **DMA's** fiscal agent. From this unit, they can obtain a Medicaid ID number for any child under the age of one year, born to and living with a Medicaid eligible woman, who is not yet enrolled in the program. In most instances, the infant is issued a Medicaid ID number shortly after delivery. Once the number is issued, a listing is sent to DFCS for follow-up eligibility. This process has served to reduce barriers to health care for the state's infants.

Other State Initiatives For Special Needs Children

The following programs are some of the state's own initiatives to provide health care to special needs children. *All* are administered by the Department of Human Resources, three by the Division of Public Health, two by the Division of Mental Health, Mental Retardation and Substance Abuse and one by an interagency team. As mentioned previously, RSM outreach workers are stationed in many county

public health departments or visit on a routine basis to process Medicaid applications. Uninsured children who present to these programs for their services are referred to outreach workers or county DFCS offices to have a Medicaid eligibility determination completed.

Division of Public Health

"Babies Can't Wait"

"Babies Can't Wait" or the Early Intervention Program is Georgia's statewide interagency service delivery system for children from birth to three years who have developmental delays or disabilities. This program guarantees that all children, regardless of their disability, have access to services that will enhance their development. Services are provided by agencies and individuals from both the public and private sectors. Some are offered at no cost. For others, state fbnds are available to assist families that have been determined unable to pay. Medicaid eligible children may participate in this program.

Children's Medical Services

Children's Medical Services (CMS), formerly the Crippled Children's Program, provides medical care to low income children with disabling conditions or chronic diseases. It also provides specialized health care for certain disorders, e.g., chronic lung disease, craniofacial anomalies, and cystic fibrosis. Eligibility is based on the age of the child (0-21 years), type of medical condition, Georgia residency and annual family income. Some services are covered by Medicaid and Medicaid eligible children may participate in this program. CMS serves approximately 15,000 to 16,000 children yearly.

Regional Perinatal System

This program is administered by the Division of Public Health with fbnding provided by the Department of Medical Assistance. It provides medical services for pregnant women and children. The pregnant women's component provides tertiary level care to high risk pregnant women. The neonatal component provides intensive care to infants. The program also provides funds to cover unmet medical costs, including neonatal transport, for infants in families with income of up to 250% of the federal poverty level. Women and children who participate in this program have been determined to be ineligible for Medicaid.

Division of Mental Health, Mental Retardation and Substance Abuse (MH/MR/SA)

Mental Health Services for Children and Adolescents with Severe Emotional Disturbance

Currently some level of services for youth with severe emotional disturbance (SED) are available in all MH/MR/SA service areas. Phase I of a statewide capacity building plan for services to SED youth

will be completed in State Fiscal Year 1999. Public services available to the SED population include:

- Outpatient including crisis intervention, case coordination and wraparound services
- In-home crisis services (to avoid hospitalization or other out-of-home placement)
- Day Treatment (after school, evenings and some weekends)
- Respite
- Therapeutic Foster Care
- Therapeutic Group Home Care

The target population are youth with a primary diagnosis of a mental health disorder diagnosable under DSM-IV which has lasted a year or is likely to last for at least a year and causes serious functional limitations in at least two or more areas, such as risk of harm to self or others, need for assistance from multiple community agencies, behavior leading to demand for public intervention, etc. Uninsured children who present to these programs for their services are referred for a Medicaid eligibility determination, but services are provided to uninsured or underinsured children on a sliding fee scale and are not denied due to inability to pay.

Substance Abuse Services for Adolescents

The public services available to youth with substance abuse diagnoses are: student assistance programs for early identification, day treatment, family treatment and adolescent residential treatment. These services are not currently available in all areas of the state. Uninsured children who present to these programs for their services are referred for a Medicaid eligibility determination, but services are provided to uninsured or underinsured children on a sliding fee scale and are not denied due to inability to pay.

Department of Human Resources

MATCH

The DHR Multi-Agency Team for Children (MATCH) Program is an interagency funding mechanism and prior approval, utilization review and discharge planning process for the purchase of out-of-community residential mental health treatment for SED children and adolescents. Local MATCH groups staff and coordinate care for their most difficult to serve SED youth. If all family and local resources are exhausted and the youngster has treatment needs that cannot be met, the local MATCH sends an application to the state level MATCH to be staffed for a treatment placement. If a treatment placement is approved, any coverage the child has for that benefit is used, but most children do not have coverage that includes residential treatment. If the child is Medicaid eligible, Medicaid will pay for the treatment portion of the cost of the placement, but not for the room and board, educational and other costs. DHR state finds are used to pay for any uncovered cost of the treatment placement for uninsured and underinsured youth.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

The State of Georgia has two (2) public-private programs which are designed to provide health care to uninsured children; however, neither of these programs offers "creditable coverage." The Medicaid program's eligibility process has a significant role in the efforts of these programs. The application process for The Georgia Partnership for Caring Program begins with the RSM Outreach Project worker. The Caring Program for Children, sponsored and partially funded by Blue Cross and Blue Shield of Georgia, receives referrals **from** outreach workers across the state.

Georgia Partnership for Caring Foundation

The Georgia Partnership for Caring Foundation (GPCF) was established in 1994 and represents a unique partnership between state government and the private sector. The mission of GPCF is to establish a free health care referral program for Georgians who cannot afford private health insurance but are not eligible for governmental medical assistance such as Medicaid or Medicare. Funding has been provided by grants from individuals, associations, and the Departments of Human Resources and Medical Assistance.

The program includes the limited voluntary services of physicians, nurse practitioners, dentists, opthalmologists, optometrists, physician's assistants, hospitals, pharmacists, pharmaceutical manufacturers, and many health provider groups and agencies. These volunteers are not paid for their services or products, but are committed to assisting Georgians obtain access to needed health care coverage. The program is available in about three-fifths of Georgia's counties. GPCF **is not insurance coverage.** It **is** not for emergencies or urgent care situations. Application processing time averages 1 month. As previously stated, RSM outreach workers are involved in the referral and application process for GPCF. They perform the screening function to determine that individuals who are referred to GPCF are not eligible for Medicaid. To date, over 4,300 individuals have participated in this program.

In addition, GPCF has recently been designated the lead agency in Georgia to apply for the Robert Woods Johnson Foundation "Covering Kids" grant. The program has collaborated with DMA and many community-based organizations in developing the grant. The proposal includes a statewide initiative related to outreach efforts and coordinating existing coverage programs (both creditable and non-creditable) for low-income children. It also includes three pilot communities who will further develop local coalitions to complement the statewide efforts.

Caring Program for Children

The goal of the Caring Program for Children is to provide primary and preventive health care coverage

Proposed Effective Date: 07/01/**98**

Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1 Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)

The Georgia CHIP legislation mandates that "Any health care provider who is enrolled in the Medicaid program shall be deemed to be enrolled in the program." Therefore, the current Medicaid child health assistance delivery and utilization control system is the proposed system for Georgia CHIP. Medicaid service delivery is, and Georgia CHIP service delivery will be, accomplished through a variety of relationships and agreements with private medical providers and state agencies.

Briefly, the current system includes a statewide primary care case management program, Georgia Better Health Care (GBHC), approved by the Health Care Financing Administration (HCFA) as a demonstration through waiver authority of section 1915(b)(1) of the Social Security Act; and a voluntary Managed Care Organization (MCO) program in four metropolitan areas of the state. The Georgia CHIP legislation allows the DMA to contract with licensed health maintenance organizations (HMOs) or provider sponsored health care organizations (PSHCCs), but prohibits required enrollment in an HMO or PSHCC as a condition of receiving coverage under the program. This plan will give families the choice of any enrolled primary care physician or provider in the GBHC program or they may choose to enroll eligible children in any of the Medicaid MCOs that are available in their county. As a condition of participation, all enrolled providers in each category of service must be fully licensed and/or certified under all applicable state and federal laws to perform the services provided to participants.

Georgia Better Health Care

This statewide program of DMA matches Medicaid recipients, and will match Georgia CHIP enrollees, to a primary care physician or provider (PCP). Through Georgia Better Health Care, DMA contracts with primary care physicians and providers to deliver and coordinate health care services for Medicaid recipients. DMA will amend those contracts to include delivery and coordination of health care services for Georgia CHIP enrollees. Two key goals of the program are to (1) improve access to medical care, particularly primary care services and (2) enhance continuity of care through creation of a "medical home."

Physician participation is open to general practitioners, family practitioners, pediatricians, general internists, and gynecologists. Physician specialists may also contract as PCPs as long as they agree to provide the services listed below. Nurse practitioners who specialize in family practice, pediatrics, or gynecology are also eligible to become PCPs. Community health centers, rural health centers, and public health department primary care clinics may be enrolled as PCPs as long as the center or clinic

has at least one full-time physician or nurse practitioner engaged in delivering primary care services, is open to the public for general medical care at least 30 hours a week, and can provide the services listed below. More than 3,500 physicians contract with DMA to serve as PCPs. They coordinate care for their members health needs by providing the following services:

- Primary care medical services, covered by Medicaid or Georgia CHIP;
- Referral authorization for needed specialty and other covered medical services; and
- Arranged **24** hour-a-day coverage.

PCPs receive a monthly case management fee of $3 per member for coordinating members' health care services, regardless of whether the member is seen. When services are provided, the regular Medicaid fee for service reimbursement applies. Regular fee for service reimbursement will also apply for services provided for a Georgia CHIP enrollee.

Unless they choose to enroll in one of DMA's MCO programs, membership in GBHC is mandatory for all Medicaid recipients, except for those residing in nursing facilities, personal care homes, mental health hospitals and other domiciliary facilities, as well as Right-from-the-Start Medicaid pregnant women and other recipients with short-term Medicaid enrollment. The same rules for mandatory enrollment in GBHC will apply to Georgia CHIP enrollees.

Medicaid recipients are given an opportunity to select a primary care case manager. For those who do not make a selection, a computer algorithm is **used** to assign a recipient to a provider. Once a PCP is auto-assigned, the recipient may change to another PCP by making a PCP selection and requesting the change. The same opportunity to select a PCP will be given to Georgia CHIP enrollees at the time of application and whenever they wish to make a change. The Third Party Administrator (TPA) who determines eligibility, handles enrollment and collects premiums for Georgia ***CHIP*** will handle the assignment of the PCP if no PCP is chosen by the Georgia CHIP enrollee. The assignment algorithm will be based on geographic convenience to a primary care provider. Historical usage of a provider may be added to the algorithm for children who have been previously enrolled and are reinstated in Georgia CHIP.

Managed Care Organization Program

The Department of Medical Assistance (DMA) developed a voluntary Health Maintenance Organization (HMO) program which was introduced initially into the metropolitan Atlanta area February 1, 1996 concurrently **with** the expansion of Georgia Better Health Care, the DMA's primary care case management program. The first expansion of the HMO program was to 19 additional counties surrounding the initial five core counties of metro Atlanta. Expansions to the Augusta, Macon and Savannah areas were accomplished in the first half of calendar year 1997, and additional expansions within current areas, **as** well **as** to other urban areas of the state, are expected in the future.

The DMA contracts with HMOs, using a model contract and a standard contract application, to provide a comprehensive array of health care services to Medicaid eligibles who choose to enroll. The DMA offers a contract to any state licensed HMO or similar entity that applies for a contract and meets the state's standards for participation. As of April 1998, two HMOs, Family*Plus* Health Plans of Georgia, Inc., and American Medical Plans of Georgia, Inc., are in operation. Additionally, Grady Healthcare, Inc., a managed care organization (MCO) entity of the Grady Health System, was contracted as a prepaid health plan on July 1, 1997, and is available to Medicaid recipients in Fulton and DeKalb counties. Total Medicaid MCO enrollment as of April 1, 1998 stands at just over 50,000. Applications for contracts from three other MCOs are currently in review.

Four key expectations for the MCO program are to (1) improve access to medical care, (2) establish a medical home and a continuum of care for enrollees, (3) improve Health Check and immunization statistics and birth outcomes, and (4) contribute to improvement in the actual health status of the enrolled population.

HMO contractors are permitted to market directly to Medicaid recipients, and as of April 1, 1998, may directly enroll them as well. The DMA contracts with an independent marketing and enrollment contractor (the MEC) to educate Medicaid recipients regarding the appropriate and timely use of medical resources, and tcrpresent all health care options available to them under the Medicaid program. The MEC focuses its marketing efforts on Medicaid recipients who are more difficult to reach. Enrollment results in Georgia to date are consistent with expectations that approximately one-third of Medicaid recipients offered a choice between Georgia Better Health Care and an HMO or similar MCO would choose a managed care organization. The same opportunity to select a MCO will be given to Georgia CHIP enrollees at the time of application.

Services that DMA requires each MCO entity to cover include hospital services and emergency care, physician services, pharmacy, dialysis, lab, radiology, orthotics/prosthetics, vision care, family planning and pregnancy-related services, Health Check, ambulance and medical equipment services, and hospice care. Other services are included, and additional, non-Medicaid services may be added by each MCO at its own expense. Services specifically excluded from coverage by the MCO program are: case management; community care; mental health services; diagnostic screening and preventive services; dental services; and non-emergency transportation. These services remain available to MCO enrollees through the Medicaid fee-for-service system. The Georgia CHIP enrollees would be covered for the same services through the MCO program as the Medicaid enrollees. The same services would also be excluded from the MCO program for Georgia CHIP enrollees. However, case management and non-emergency transportation would not be available to Georgia CHIP enrollees through fee-for-service, because these services are excluded by the Georgia CHIP legislation.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

The utilization controls under Georgia CHIP will be the same controls used under the Medicaid program.

Reimbursement Limitations

The federal government allows DMA to place appropriate limits in regard to medical necessity and utilization control. Reimbursement limitations such as prior approval requirements, service limitations, non-covered procedures, and eligibility limitations are used by DMA to guarantee appropriate utilization of funds.

GBHC

In addition to the key expectations discussed under 3.1, a key goal of GBHC is to reduce unnecessary use of medical services. Medicaid recipients who are members of GBHC have a Medicaid card which lists the name, address, and telephone numbers of the member's PCP. Georgia CHIP enrollees will have a membership card that looks different from the Medicaid card, but which will include the PCP information. Medicaid providers other than the member's PCP generally must obtain authorization from the PCP in order to be reimbursed for services provided to the GBHC member. These same providers will be Georgia CHIP providers and will have to obtain authorization from the PCP under the same circumstances as they do for Medicaid, in order to be reimbursed for services. Authorization can be obtained by contacting the PCP listed on the member's card. Certain services are exempt from the PCP authorization requirement. Providers will be able to contact the TPA's member services line, to confirm exemptions.

DMA estimates that the GBHC program has saved the state and taxpayers more than $54 million in its first three years of existence by appropriately controlling utilization, improving access to primary care services and enhancing continuity of care. A study by Georgia State University economists estimates that GBHC saved 3.3% of regular fee-for-service Medicaid costs. Improving members' access to primary care resulted in savings through reduced likelihood of hospitalization for serious illnesses. GBHC also reduced the number of unnecessary visits to emergency rooms for non-emergency care and to specialists for care that could be provided through a primary care physician.

MCOs

In addition to the key expectations discussed under 3.1, other key goals of the MCO program are to reduce inappropriate utilization of medical resources and to reduce Medicaid program expenditures. MCOs are paid an actuarially certified, average monthly per capita rate based on historical Medicaid

fee-for-service claims experience. The rates are age and gender specific by aid category, and include Low Income Medicaid eligibles (formerly Aid to Families with Dependent Children (AFDC)), Right from the Start Medicaid children (SOBRA eligibles), and SSI eligibles, both with and without Medicare. ALL MCOs are paid the same rates for the same service area, which are less than expected fee-for-service Medicaid expenditures for an equivalent population. All participating MCOs are required to provide the same Medicaid services and can provide expanded benefits for the same payment, which many do to encourage enrollment. Recipients who enroll are not subject to copayments or some of the service limitations in place in the regular Medicaid program. Georgia CHIP enrollees will have the same choices of MCOs in the same locations of the state as Medicaid recipients.

Surveillance Utilization Review

The Surveillance Utilization Review Services (SURS) used by DMA for the Medicaid program to perform both peer and recipient review functions will also be used by DMA for Georgia **CHIP.** The purpose of SURS is to safeguard the quality of care and to identify, correct and prevent misutilization of services. DMA has a contract with Health Care Solutions to perform specific SURS functions. Descriptions of certain of these functions follow.

Practitioner reviews require a review of medical documentation to support the services billed to DMA. The review must be performed by a peer of the practitioner under review. Most practitioner reviews relate to the medical necessity and appropriateness of a billed service (claims specific review). The claim specific reviews assess the medical necessity, appropriateness of care, billing patterns and/or overall utilization patterns of an individual provider. Other practitioner reviews look at a pattern of questionable services (pattern of practice review). The patterns of practice reviews examine services provided to recipients to assess the quality, necessity and overall standard of care. This review addresses specific concerns related to medical necessity of a service, procedure or hospitalization; standard of practice for cases in which the service rendered is contrary to known medical practice patterns; patterns of practice for a consistent, documented, over or under utilization of service; and quality concerns related to a pattern or an isolated incident affecting the health or well-being of a recipient. This could represent a suspected pattern of over or under utilization of services or pattern of substandard performance.

Recipient reviews are used to determine the medical necessity for the number and frequency of services received for the treatment of acute and/or chronic spells of illness. These reviews verify that services were rendered; determine medical necessity for the number, setting and frequency of services received (emergency room, inpatient and office visits); assess quality of care/services rendered; assess and identify the need to refer the recipient to other DMA programs such as Lock-in (for continuity of care); or identify potential providers for review of aberrant practices.

Pharmacy Prior Approval

Prior approval is used for management of the quality and cost of outpatient prescription drug treatment. It is required for more than 100 drugs in the Georgia Medicaid program: some psychotropic medications, as well as amphetamines, anabolic steroids, growth hormones, interferons, testosterone injections, and blood clotting factors, among other less well known drugs. Prior approval is required for all brand name drugs for which there is a generic substitute. Ninety-three percent of the requests made for drugs on DMA's prior approval list are approved. That approval comes after screening by the Georgia Pharmacy Foundation, DMA's prior approval authority, Its clinical pharmacists examine each request, and a board certified internal medicine specialist reviews any denials or appeals. Approval is generally based on the FDA approved and medically accepted indications for use.

Dental Services Prior Approval

Diagnostic and preventive services are excluded from prior approval since the goal of these services is to identify the need for dental care and dental problems early, which results in better care and in cost savings to the dental program. Some other services require prior approval. Prior approval provides two administrative controls: (1) it ensures medical necessity and appropriateness of treatment; and (2) it controls the dollar amount expended for each recipient. In the course of prior approval reviews in the dental program, alternate procedures and courses of treatment consistent with the prudent buyer concept are often recommended.

Treatment Residential Intervention Services Utilization Controls

The DHR Multi-Agency Team for Children (MATCH) Program, which was described under Section 2.2.1, is an interagency fbnding mechanism and prior approval, utilization review and discharge planning process for the purchase of out-of-community residential mental health treatment for SED children and adolescents. If the child is Medicaid eligible, Medicaid covers the treatment portion of the cost of the placement, but not the room and board, educational and other costs. As previously described, local MATCH groups staff and coordinate care for their most difficult to serve SED youth. If all family and local resources are exhausted and the youngster has treatment needs that cannot be met, the local MATCH sends an application to the state level MATCH to be staffed for a treatment placement. The local process includes a gatekeeping function as well as a coordination function.

At the state level, applications are reviewed and given prior approval or are denied based on an evaluation system which includes an assessment score based on the child's past and current clinical and social history, diagnosis, involvement with and services from other child-serving agencies and an assessment score based on the child's behavior and functioning. If approved and placed for residential

treatment, the MATCH group (state level with local level participation) performs an on-site utilization review every six months from admission to discharge. Clinical, behavioral and functional outcomes are measured on a regular basis and are used as part of the utilization review process, along with interviews with the children and their clinicians. At the end of each utilization review an estimated discharge date is set that goes into effect unless clinical indicators change and an extension is sought and approved. This same prior approval, utilization review and discharge planning process will be used for Georgia CHIP enrollees.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A))

4.1.1 ☐ Geographic area served by the Plan: Georgia's Title XXI plan will be available statewide to children in all 159 Georgia counties.

4.1.2. ☐ Age: The plan will be available to children 0 through 18 years of age. If the child is otherwise eligible, coverage will continue through the month of his/her nineteenth birthday.

4.1.3. ☒ Income: Eligible children will have family income that is at or below 200% of the federal poverty level and will not be eligible for Medicaid. *See* Attachment 3 for a description of family size and income criteria.

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources): There will be no resource test.

4.1.5. ☒ Residency: Georgia residency will be required. Residency will be based on current circumstances. There will be no requirement that a child have lived in Georgia a specified length of time prior to application.

4.1.6. ☐ Disability'Status (so long as any standard relating to disability status does not restrict eligibility): No child will be denied eligibility based on disability status.

4.1.7. ☒ Access to or coverage under other health coverage: A child will be denied eligibility if it is determined that he or she: 1) is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or 2) is eligible for Medicaid; or 3) is a member of a family that is eligible for health benefits coverage under a State health benefit plan based on a

family member's employment with a public agency in the State; or 4) voluntarily dropped coverage under an employer plan during the past three months. (Voluntary termination of coverage does NOT include the following: employer cancellation of the entire group plan; loss of eligibility due to parent's layoff, resignation of parent from employment, employment termination; leave of absence without pay, or reduction of work hours; or cancellation of COBRA or an individual insurance policy. A child born during the three month waiting period would be eligible.) The CHIP application will contain questions about current and past coverage under group health plans and family members employment with State agencies. Employer information will also be validated by checks of wage record data with the Georgia Department of Labor, when available. This information will prevent the enrollment of children with other health coverage. Once the children are enrolled, there will be periodic checks of the DOL files to determine if there have been changes in employers. In addition, as claims are paid, if the providers report coverage under other health plans, eligibility will be terminated if the coverage meets any of the four criteria listed above.

4.1.8. ☐ **Duration of eligibility:** With the approval of the *CHIP* application, a child will be eligible for twelve months as long as eligibility criteria continue to be met. The family will be notified of their responsibility to report changes in income, residency or health insurance coverage. At six month intervals, there will be checks with the Georgia Department of Labor for evidence of an increase in income over the 200% federal poverty level or employment with a State agency. There will be monthly matches with the Department of Medical Assistance's recipient database to ensure that Title XXI children have not been certified for Medicaid. At the end of the twelve month eligibility period, the family will file another application and eligibility will be determined for another twelve month period.

4.1.9. ☐ **Other standards (identify and describe):** None

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B))

4.2.1. ☒ **These standards do not discriminate on the basis of diagnosis.**

4.2.2. ☒ **Within a defined group of covered targeted low-income**

children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3 Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2))

The State will use the same income methodologies as are used for its Right from the Start Medicaid program (Title XIX Poverty Level Group)..

The State plans to contract with a Third Party Administrator (TPA) who will be responsible for receiving CHIP applications, screening for Medicaid eligibility, determining CHIP eligibility, processing monthly premium payments and enrolling children in either an MCO or the Georgia Better Health Care program.

Customer Service will be a major component of the functions required of the Third Party Administrator. The TPA's telephone customer service staff will be expected to furnish CHIP applications upon request, provide assistance to clients who may have questions about the program in general or who may need assistance in the completion of the forms. In addition, the customer service staff will provide support to the client in their choice of an MCO or a GBHC primary care provider. They will be available to answer questions about the managed care programs and to provide written information to clients to facilitate their choices. The customer service staff will also be responsible for responding to Medicaid providers who need to verify clients Medicaid eligibility and service limitations.

The following process will be used to establish eligibility and continuing enrollment:

APPLICATION

The state will use a specially designed application form for the CHIP program. See Attachment 4 for a draft of the application. This application will gather information about the applicant children and their parents. Requested information will include:

Social Security Numbers of family members

- Amount, frequency and source of earned and unearned income
- Amount, frequency and source of child care expenses
- Health insurance status of family members
- Current address
- U. S. Citizen/Lawful Alien Status
- HMO Plan Choice or PCP for GBHC program

Applications will be in an easy to understand format. Families may mail in the completed applications

for processing. The Administrator will provide telephone assistance through a 1-800 number to clients who request help in completing the application. Caseworkers in the RSM Outreach Project will also be available for clients who wish to have a face-to-face interview.

The application will also contain the information necessary for processing a Medicaid application. The Medicaid eligibility worker should be able to process the application for RSM Medicaid with only minimal interaction with the client.

APPLICATION PROCESSING

Upon receipt of the application, the TPA will screen the application for potential Medicaid eligibility. If, based on a check of the DMA's Information System, the child is a current Medicaid enrollee, the Administrator will deny the application for CHIP. If the child is potentially Medicaid eligible based on reported income, the TPA will route the application to the State's Medicaid eligibility unit for a determination of Medicaid eligibility. For children who are not Medicaid eligible, the TPA will determine if: net family income is at or below the 200% federal poverty level; the child is covered by a group health plan (either currently or in the past three months); the child is eligible for health benefits through a family member's employment with a state agency; and if the child is a U.S. citizen or lawfully admitted alien.

To support the client's statements on the application, the TPA will be required to check the Georgia Department of Labor files for the most recent wage information available for the appropriate family members. This information will help to validate the client's statement regarding earned income and will substantiate the name of the employer to determine that there is no family member employed by a state agency. The TPA will also check the Georgia Merit System files for potential eligibility under the state's health benefit plan. The TPA will also be required to use customer service personnel to follow up on incomplete or unclear information found in the application.

If a child is determined to be ineligible for CHIP, the family will receive a written notice describing the reason for ineligibility. The notice shall specify the reason for the denial (e.g. excess income, age over eighteen years etc.) The notice shall also specify the applicant's opportunity to request a reconsideration of the decision and related procedures to accomplish this. This may include submission of additional or clarifying information to allow a review of the application decision. If the client is not satisfied with the final decision of the TPA, the case will be sent to DMA for further review.

If a child is found to be eligible for the CHIP program, the family will receive a notice describing available benefits, a confirmation of the MCO (Managed Care Organization) or GBHC (Georgia Better Health Care) Primary Care Provider selected by the family (if a selection was made), instructions on how to submit premium payments and a number to contact the TPA to report changes.

CONTINUING ENROLLMENT

At the time of application approval, the family will receive information requiring them to report changes in their income, place of residence or household size to the TPA. If these changes would result in ineligibility, the TPA will send the client a notice of termination and close the case. The notice shall specify the reason for termination (e.g. excess income, age over eighteen, years etc.) The notice shall also specify the applicant's opportunity to request a reconsideration of the decision and related procedures to accomplish this. This may include submission of additional or clarifying information to allow a review of the termination decision. If the client is not satisfied with the final decision of the TPA, the case will be sent to DMA for further review.

In addition, at six month intervals, the TPA will check the DOL database to determine the following: 1) if the family has increased income that would place them over 200% of the FPL, 2) if the family has decreased income that would make them within the Medicaid limits or 3) if a parent has obtained employment with a state agency which offers health benefits under the state health benefit plan. If any of these indicators of possible ineligibility are found, the TPA will contact the client, relay the information and give them an opportunity to provide evidence of their continuing eligibility. If there is no successful rebuttal of the information, the case will be closed for CHIP. In the event that there is potential Medicaid eligibility, the case will be referred to the Medicaid unit for handling.

As long as the family continues to meet all eligibility requirements and continues to pay the monthly premium as required, the child(ren) may be eligible for coverage for twelve (12) months.

PREMIUM COLLECTION and REINSTATEMENT PROCESS

- Premiums: Children ages 0-5 $0
  Children ages 6-18 $7.50 (1 child) $15.00 (2 children)
- Applicant must submit 1 month's premium with application for it to be complete. Once determined eligible enrollment occurs by first of next month.
- When applicant is enrolled, the TPA will send a coupon payment book (or other payment mechanism) to the enrollee for use in making regular premium payments. Clients may send in premiums for multiple months.
- The first month's coverage will be funded with state/federal funds. The premium sent with application will be applied to the second month's coverage. With this model, the collection process will be one month ahead of coverage and an enrollee has 30 days after being late with a payment to submit it before coverage is terminated.
- If payments are late, the notification/cancellation process will begin. Two letters will be sent before cancellation occurs.

An example follows:

Date	Event
January 6th	Applicant submits complete application.

January 16th	Eligibility is determined. Applicant is enrolled, if eligible.
February 1st	Enrollee is eligible to start receiving benefits. State/federal dollars fund February's coverage.
March 1st	Parental premium submitted with application is applied to March's coverage. April premium is due.
March 10th	April premium is late, if not yet received.
March 31st	If April premium has not been received, cancellation will occur,

- If coverage is terminated due to nonpayment of premium, coverage may be reinstated at any time within the 12 month eligibility period, with the payment of premiums for the next two months. Coverage will resume the first of the next month.

4.4. Describe the procedures that assure:

4.4.1. Through intake and follow up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (section 2102)(b)(3)(A))

Upon receipt of the application, the TPA will screen the application for potential Medicaid eligibility. If, based on a check of the **DMA's** Information System, the child is a current Medicaid enrollee, the TPA will deny the application for ***CHIP.*** If the child is potentially Medicaid eligible based on reported income, the TPA will route the application to the State's Medicaid eligibility unit for a determination of Medicaid eligibility.

For children who are not Medicaid eligible, the TPA will determine if the child is covered by a group health plan or eligible for health benefits through a family member's employment with a state agency. To support the client's statements on the application, the TPA will be required to check the Georgia Department of Labor files for the most recent employer information available for the appropriate family members. This information will help to validate the client's statement and will substantiate the name of the employer to determine that there is no family member employed by a state agency. The TPA will also check the Georgia Merit System files for potential eligibility under the state's health benefit plan.

Once the child is enrolled in the ***CHIP*** program, monthly checks will be made of the Medicaid Information System to insure that the child has not been approved for Medicaid while eligible for ***CHIP*** benefits.

In order to insure the integrity of the program, DMA's Quality Control Unit will conduct periodic reviews of a random sample of approved, denied and terminated CHIP cases. These reviews will be patterned after the Title XIX Medicaid Eligibility Quality Control (MEQC) process. The client will be contacted and all eligibility elements be verified through information gathered from the primary

source. In this way, the state can be assured that only targeted low-income children without other creditable coverage are being served by the CHIP program,

4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))

Upon receipt of the CHIP application, the TPA will screen the application for potential Medicaid eligibility. If, based on a check of the **DMA's** Information System, the child is a current Medicaid enrollee, the TPA will deny the application for CHIP. If the child is potentially Medicaid eligible based on reported income, the TPA will route the application to the State's Medicaid eligibility unit for a determination of Medicaid eligibility.

The State plans to house a minimum of 2 (two) state employed eligibility workers at the TPA site in order to streamline the processing of applications for children who, through the screening process, appear to be Medicaid eligible. These workers would process the CHIP application for Medicaid and approve the child for Medicaid if eligible.

4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))

A child will be denied eligibility if it is determined that he or she: 1) is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or 2) is eligible for Medicaid; or **3) is** a member of a family that is eligible for health benefits coverage under a State health benefit plan based on a family member's employment with a public agency in the State; or **4)** voluntarily dropped coverage under an employer plan during the past three months. (Voluntary termination of coverage does NOT include the following: employer cancellation of the entire group plan; loss of eligibility due to parent's layoff, resignation of parent from employment, employment termination; leave of absence without pay, or reduction of work hours; or cancellation of COBRA or an individual insurance policy. A child born during the three month waiting period would be eligible.)

The CHIP application will contain questions about current and past coverage under group health plans and family members employment with State agencies. Employer information will also be validated by checks of wage record data with the Georgia Department of Labor, when available. This information will prevent the enrollment of children with other health coverage. Once the children are enrolled, there will be periodic checks of the DOL files to determine if there have been changes in employers. In addition, as claims are paid, if the providers report coverage under other health plans, eligibility will be terminated if the coverage meets any of the four criteria listed above.

4.4.4. The provision of child health assistance to targeted low-income

children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))

There are no children who meet this definition.

4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))

Currently, Georgia's **only** public child health insurance plan is the Medicaid program administered by the Department of Medical Assistance. See Sections **2.2.1, 2.2.2, 2.3., 4.4.1, 4.4.2, 4.4.3** and **5.2.** which discuss issues related to coordination of Georgia CHIP with Georgia Medicaid, other public child health programs, public-private programs which are designed to provide health care to uninsured children, and other public and private health insurance programs which provide creditable coverage for low-income children.

Section 5. Outreach and Coordination (Section 2102(c))

Describe the procedures used by the state to accomplish:

5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))

Current Medicaid Outreach Efforts

RSM Outreach Project

The Right From the Start Medicaid (RSM) Project began in July 1993 as Georgia's response to the high infant mortality rate and to improve health care access for all children and pregnant women.

The Department of Medical Assistance (DMA) and the Department of Human Resources (DHR) entered into an agreement to place eligibility workers in community settings. The agreement provides for 143 eligibility workers. These staff currently have offices in health departments, hospitals, clinics, day care centers, schools, community action agencies and other locations in the community. A major feature of the program is the availability of staff during non-traditional work hours so that clients may apply for RSM without having to lose time from their jobs or from school. Non-traditional hours are defined as any time other than 8 a.m. to 5 p.m. Monday through Friday.

Outreach staff are housed throughout Georgia and, although not housed in all 159 counties, provide Medicaid enrollment information and access to the Medicaid application process in every county. This involvement with potential Medicaid clients on a local level greatly enhances Georgia's outreach efforts. Outreach staff also actively pursue collaboration with other agencies and groups in their communities in order to maximize involvement at the local level and to educate other agencies in the basics of Medicaid eligibility and the availability of Medicaid services and to provide for mutual referral systems. Most of the local RSM project staff have partnerships with the county health departments, local schools, pregnancy centers, battered women's shelters, Head Start programs and the health care community in their areas.

Workers and supervisory staff make presentations regularly to community groups, medical providers and employers. RSM project staff often participate in health fairs and other local activities in order to reach potential Medicaid clients. Staff have utilized creative techniques for distributing information to the public. Medicaid flyers have been sent home with school age children and workers have visited day care centers to pass out brochures. Employer contacts have resulted in opportunities to distribute literature through personnel offices and at employee forums, and to accept applications at job sites.

Simplified Application Form

Georgia has developed a Sipliied application form for use by pregnant women and children applying for RSM Medicaid. The application is designed as a one page, two-sided brochure. The Medicaid application form is on one side. The reverse has some basic facts about the Medicaid program and has an address area so the form can be mailed in. This form has been in use since **1993.**

Outreach Publications

Georgia has published a series of brochures designed to educate and encourage enrollment in the potential Medicaid population. Each of the brochures targets a different group of Medicaid eligibles, gives a brief description of benefits available through Medicaid and a summary of Medicaid eligibility requirements. There is a brochure targeting each of the following groups: **1)** Pregnant Women, **2)** Newborns, **3)** Children, **4)** Teenagers, and *5)* Families who have lost cash assistance benefits.

In addition, Georgia uses brochures designed by the Southern Institute on Children and Families to specifically target working families. These brochures emphasize that Medicaid, and other benefits, are still available to many families when the parent goes to work.

New Outreach Efforts for Georgia CHIP and Medicaid

Georgia CHIP Outreach Through RSM Outreach

Outreach efforts will be completely coordinated for Georgia CHIP and Medicaid, so that those children who are eligible for Medicaid will be reached and enrolled in Medicaid and those children eligible for Georgia CHIP will be reached and enrolled in Georgia CHIP. The outreach efforts will target all children at or below 200% of the FPL. To build on and enhance our current outreach efforts, Georgia will utilize our nationally recognized RSM outreach strategies for Georgia ***CHIP.*** RSM outreach workers will have available all pertinent information for both Medicaid and Georgia CHIP. The outreach workers will have a variety of program information on both creditable and non-creditable coverage and other ways to access health care services. The order of priority for the outreach workers will be first to locate uninsured children, second to determine eligibility for Medicaid, third to provide information and assistance regarding enrollment in Georgia CHIP, fourth to provide information on the Georgia Partnership for Caring Foundation, the Caring Program for Children and DHR public health care programs and services. The outreach efforts will also be coordinated with community based organizations and health care providers.

Simplified ***CHIP*** Application Form

Georgia has developed a simplified application form for use by families who appy for the CHIP program. The application is designed as a one page, two-sided form and is modeled on the RSM application currently in use. The form is designed to gather information needed to determine

eligibility for both CHIP and the Medicaid programs. (Attachment 4)

Marketing and Public Awareness

DMA will obtain the services of a qualified marketing, advertising, public relations or graphic design firm and/or consultants to develop a name, logo and program identity that will appeal to the target populations for Georgia CHIP.

DMA will also obtain the services of a qualified marketing, advertising, or public relations firm and/or consultants to develop a statewide marketing and awareness program for Georgia ***CHIP*** to encourage enrollment in Georgia ***CHIP,*** and to increase enrollment in Medicaid. A Request for Proposal will be let to:

- Describe the marketing needs of Georgia ***CHIP;*** and
- Solicit a response fiom vendors that documents the extent to which their proposed approach and products satisfy the marketing needs of Georgia ***CHIP;*** and
- Solicit a bid for marketing Georgia ***CHIP*** that includes the development of a program identity, use of key messages, and development and delivery of print and media campaign products, and development of plans identifying the target for public awareness and mass media campaigns and for coordinated efforts with community based organizations and health care providers.

The potential vendors will be asked to:

A. Incorporate key messages and the program identity in the development of products and materials. Some of the key messages include but are not limited to:
   - Health care is important for your children.
   - Health care insurance coverage can provide important preventive care to keep your children healthy.
   - Healthy children miss fewer days of school and do better in school.
   - Health care coverage for children is now more accessible and affordable.
   - Georgia now has programs like Georgia ***CHIP*** that can help.
   - A simple application process makes it easier for families to enroll,
   - Call 1-800-XXX-XXXX for more information.

B. Communicate effectively with potential eligibles. At a minimum the products and materials must be in English and Spanish. However, the contractor will be encouraged to give strong consideration to languages that will reach other ethnic populations such as the Asian population. Focus must be on the following groups in the development of the program identity and in the development of products and materials:

   - Ethnically and linguistically diverse Georgia families at or below 200% FPL with uninsured children 0 through 18 years of age;
   - Families with one or both parents employed at or below 200% FPL with uninsured children 0 through 18 years of age;

- Families without knowledge of, or access to, affordable health care coverage for their children, including families whose children may be eligible to be enrolled in Medicaid;
- Community-based programs that deal with potentially eligible children and their families such as schools, religious organizations, community health clinics, child care and after-school programs, etc. and;
- Employers with employees who do not receive health care benefits.

C. Develop a plan for an initial public awareness and mass media campaign to reach specific targeted subgroups and to ensure that a diverse cultural, linguistic and geographic mix of the populations is reached including:

- Coordinated efforts with community-based organizations that deal with potentially eligible children and/or their families;
- Encouragement of health care providers to inform families about Georgia CHIP as well as targeting the potentially eligible families;
- Utilization of market and health information/data regarding the target populations, and incorporation of this information/data into overall strategic campaign planning, including messages, promotions and products.

D. Using the program logo supplied by DMA, expand the program recognition using slogans, and other methods to enhance the appeal of the program to all segments of the targeted population. Communicate key messages to the target groups through the development of products and materials for the initial campaign. Examples are:

- Educational and informational brochures
- Applications
- Posters
- Public Service Announcements
- Press releases
- Public transportation ads
- Media Kits
- Enrollment Kits
- Training Kits
- Radio and Newspaper Ads
- Special Incentive Items which display logo or other information
- Promotional materials for use by community-based organizations, health care providers
- Talking Points and Overheads for presentations
- Television Ads
- Billboards
- Informational Video

E. Complete development of products and materials (following approval of final drafts) by having

As part of this outreach effort, any new program materials, such as applications and brochures will be produced in Spanish and any other language that is represented by a significant portion of the population.

Evaluation

We intend to expand our ongoing evaluation of the RSM Outreach Project. We also plan to evaluate the marketing campaign. In order to increase the percentage of eligibles who would be enrolled in CHIP or Medicaid, we will need to better understand the links between outreach efforts and client enrollment. We need to know what outreach efforts are the most effective in increasing which enrollments. By understanding these links we can focus on the outreach efforts that are most successful in increasing appropriate enrollments.

5.2. Coordination of the administration of this program with other public and private health insurance programs: (section 2102(c)(2))

The administration of Georgia CHIP and Medicaid will be coordinated by DMA which will administer both programs. DMA also plans to reorganize its existing advisory committee structure to include an Advisory Committee on Child Health. To help ensure coordination, it is envisioned that representatives from other public and private health insurance programs will serve on that committee. In addition, the RSM project staff coordinate their outreach efforts with all other public and private programs both on a state and a local level. As explained previously, the RSM workers work closely with county health departments, FQHCs, DSH hospitals, schools, and other child-serving agencies to ensure that Medicaid eligibility and service information is disseminated and that potentially eligible clients have their Medicaid eligibility determined. RSM state staff meet with the administrators of the Partnership for Caring Program and with the Caring Program for Children to ensure that policies for those programs are followed and that efforts to reach targeted clients are coordinated. All this coordination will be expanded to include the Georgia CHIP.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.)

6.1.1. ☒ Benchmark coverage; **(Section 2103(a)(1))**

a. 1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2))** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). See instructions.

The Bluechoice Health Care Plan, the state's HMO with the largest enrollment, is the benchmark plan. The benefit plan for Georgia CHIP is the benchmark coverage with added services to bring the coverage to equal a Medicaid look-alike, with the exceptions of non-emergency transportation, targeted case management, services solely for persons over age 19, and some services that to be needed require a level of disability that would qualify the child for Medicaid. See Attachment 5 for a comparison of the BlueChoice Plan and the Georgia ***CHIP*** Benefit.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3))** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage."

6.1.4. ☐ **Secretary-Approved Coverage.** (Section 2103(a)(4))

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (section 2110(a))

These services are the same as the services in the Georgia Medicaid Plan with the exceptions of non-emergency transportation, targeted case management, services solely for persons over age 19, and some services that to be needed require a level of disability that would qualify the child for Medicaid. All these services are subject to the same limitations and prior approvals as they are in the Georgia Medicaid Plan.

6.2.1. ☒ **Inpatient services** (section 2110(a)(1))
Inpatient services include medical and surgical services delivered during a hospital stay. Inpatient services are covered in full. See 6.2.10 for coverage for psychiatric hospital services. Prior approval is needed for some services.

6.2.2. ☒ **Outpatient services** (section 2110(a)(2))
Outpatient services include outpatient surgery, clinic services and emergency room care. Outpatient services are covered in full. Prior approval is needed for some services.

6.2.3. ☒ **Physician services** (Section 2110(a)(3))
Physician services include services provided by a participating physician for the diagnosis and treatment of an illness or an injury. Physician services are covered in full. Prior approval is needed for some services.

6.2.4. ☒ **Surgical services** (section 2110(a)(4))
Surgical services are covered in full. See 6.2.1 for inpatient surgical services and 6.2.2 for outpatient surgical services. Prior approval is needed for certain procedures.

6.2.5. ☒ **Clinic services (including health center services) and other ambulatory health care services.** (section 2110(a)(5))
See 6.2.2 above.

6.2.6. ☐ **Prescription drugs (Section 2110(a)(6))**

Prescribed drugs (from participating drug rebate manufactureres) and supplies approved by DMA and dispensed by an enrolled pharmacist are covered in full. Some drugs require prior approval or have therapy limitations. Prescriptions or refills are limited to six per month per enrollee. There are procedures in place that allow recipients to receive medically necessary prescriptions in excess of six (6) per month. CHIP enrollees in an MCO program are not subject to this limitation.

6.2.7. ☒ **Over-the-counter medications** (Section **2110(a)(7))**

The following non-prescription drugs are covered in full: Multi-vitamins and multiple vitamins with iron, enteric coated aspirin, diphenhydramine, insulin, N E , iron, meclizine, insulin syringes, insulin delivery unit systems (NOVO pen for example) and urine test strips. No other over-the-counter medications are covered.

6.2.8 ☒ **Laboratory and radiological services (Section 2110(a)(8))**

Medically necessary laboratory testing is covered if performed by a physician.

Radiology services are covered in a hospital setting or in a physician's office only. Note: laboratory and radiological services are covered as two separate services.

6.2.9 ☐ **Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))**

These services are covered in full. This includes Childbirth Education Services, a series of 8 classes regarding the birth experience and tools to prepare for a healthier pregnancy, birth and postpartum period.

6.2.10 ☒ **Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))**

Inpatient mental health services are covered only for short term acute care in general acute care hospitals up to 30 days per admission. Services furnished in a state-operated mental hospital are not covered. Services furnished in an Institution for Mental Disease (IMD) are not covered. Residential or other 24-hour therapeutically planned structural services are covered only through the DHR MATCH Program. (See Sections 2.2.1. and

3.2.) Psychotherapy is limited to 10 hours per calendar month.

6.2.11. ☒ **Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services** (Section 2110(a)(11))

Outpatient mental health services are covered through: Community Mental Health Centers, subject to limitations specified in DHR standards.

6.2.12. ☒ **Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)** (Section 2110(a)(12))

Durable medical equipment and supplies prescribed by a physician are covered. Prior approval is required for custom molded shoes and for repairs to certain prosthetic devices. Hearing aids are allowed every three years without prior approval. Medical necessity for hearing aids must be approved by Children's Medical Services. This prior approval is based upon the completion of a hearing evaluation by prescribing physician or other licensed practitioner. Medical equipment purchases and one-way mileage for delivery in excess $200.00 require prior approval. See Vision Care under 6.2.28 for eyeglasses.

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6.2.13. ☐ **Disposable medical supplies** (Section 2110(a)(13))

6.2.14. ☒ **Home and community-based health care services (See instructions)** (Section 2110(a)(14))

Home health services, ordered by a physician and provided in the enrollee's home, including part-time nursing services, physical, speech and occupational therapy, and home health aide services are covered for **75** visits per calendar year. Home health services exceeding **75** visits per calendar year may be covered when requested by a physician and determined to be medically necessary by DMA.

6.2.15. ☒ **Nursing care services (See instructions)** (Section 2110(a)(15))

Nursing care services are covered as follows. The Nurse Practitioner Services Program reimburses for a broad range of medical services provided by participating Pediatric, Family, Adult, and OB/GYN Nurse

Practitioners, as well as Certified Registered Nurse Anesthetists (CRNA). Nurse Midwife services are also covered and include primary care services in addition to obstetrical care.

6.2.16. ☒ **Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)**

6.2.17. ☒ **Dental services (section 2110(a)(17))**
Dental and oral surgical services are covered as follows: 2 visits (initial or periodic) for dental exams/screens and 2 emergency exams during office hours and two emergency exams after office hours per calendar year are allowed; 2 cleanings per calendar year; 1 restorative (filling) procedure per tooth per restoration; the maximum number of surfaces covered is four (4); sealants for first and second permanent molars only; orthodontic services with prior approval.

6.2.18. ☒ **Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))**
Inpatient substance abuse treatment services are covered only for short term acute care in general acute care hospitals up to 30 days per admission. Services furnished in a state-operated mental hospital are not covered. Services furnished in an Institution for Mental Disease (IMD) are not covered.

6.2.19. ☒ **Outpatient substance abuse treatment services (Section 2110(a)(19))**
Outpatient substance abuse treatment services are covered through Community Mental Health Centers, subject to limitations specified in DHR standards. Outpatient short term acute care and substance abuse treatment services are covered in general acute care hospitals.

6.2.20. ☐ **Case management services (Section 2110(a)(20))**

6.2.21. ☐ **Care coordination services (Section 2110(a)(21))**

6.2.22. ☒ **Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))**
Physical, occupational and speech pathology therapy are covered as follows: 1 hour per day up to 10 hours per calendar month for physical therapy; 1 hour per day up to 10 hours per calendar month for occupational therapy; 1 session per day up to 10 sessions per month

for individual speech therapy. With prior approval these limits may be exceeded. See also Children's Intervention Services below.

6.2.23. ☐ **Hospice care** (Section 2110(a)(23))
Covered under a plan of care when provided by an enrolled hospice provider.

6.2.24. ☐ **Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions)** (Section 2110(a)(24))

6.2.25. ☐ **Premiums for private health care insurance coverage** (Section 2110(a)(25))

6.2.26. ☒ **Medical transportation** (Section 2110(a)(26))
Emergency ambulance services are covered for an enrollee whose life and/or health is in danger. Non-emergency transportation is not covered.

6.2.27. ☐ **Enabling services (such as transportation, translation, and outreach services (See instructions)** (Section 2110(a)(27))

6.2.28. ☐ **Any other health care services or items specified by the Secretary and not included under this section** (Section 2110(a)(28))

Health Check: Regular physical examinations (screening), health tests, immunizations and treatment for diagnosed problems are covered. Screening requirements are based on the recommendations for preventive pediatric health care adopted by the American Academy of Pediatrics. Treatment is covered within the limitations on covered services.

Vision Care: Services including eyeglasses, refractions, dispensing fees, and other refractive services are covered. Medically necessary diagnostic services are also covered. Limitations are: 1 refractive exam, optical device, fitting, and dispensing fee within a calendar year; additional such services require prior approval. Prior approval is also required for other services including but not limited to: contact lenses, trifocal lenses, oversized frames, hi-index and polycarbonate lenses.

Children's Intervention Services: Services covered for children from birth through 18 years of age are audiology, nursing, nutrition, occupational therapy, physical therapy, social work, speech-language pathology and developmental therapy

instruction. Written prior approval is required for medically necessary Children's Intervention Services once the annual service limitations listed in the ***Policy*** and ***Procedure*** Manual have been reached. Individualized Family Service Plan is required to document medical necessity for amount, duration and scope of services, Note that children 18 years of age are not covered under these program services.

Family Planning: Covered services include initial and annual examinations, follow-up, brief and comprehensive visits, pregnancy testing, birth control supplies, and infertility assessment.

Pregnancy-Related Services: Covered services help reduce infant mortality by providing home visits that assess the mother and child and teach the mother about specific subjects that will reduce infant mortality.

Podiatry: Services covered are diagnosis, medical, surgical, mechanical, manipulative and electrical treatment of ailments of the foot or leg as authorized within the Georgia statute governing podiatric services.

Physicians Assistant Services: Covered services are limited to primary care services and anesthesiologist's assistant services authorized in the basic primary care job description, approved by the Georgia Composite State Board of Medical Examiners.

End Stage Renal Disease (ESRD) Dialysys: Services and procedures designed to promote and maintain the functioning of the kidney and related organs are covered when provided by a provider enrolled in the ESRD program. Acute renal dialysis services are covered under other programs.

6.3. Waivers - Additional Purchase Options, If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (section 2105(c)(2) and(3))

Georgia is planning no waiver requests at this time.

6.3.1. ☐ Cost Effective Alternatives. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (section **2105(c)(2)(B)(i))**

6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and Describe the cost of such coverage on an average per child basis. **(Section 2105(c)(2)(B)(ii))**

6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. Describe the community based delivery system. **(section2105(c)(2)(B)(iii))**

6.3.2. ☐ Purchase of Family Coverage. Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3))**

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) **(Section 2105(c)(3)(A))**

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B))**

Section 7. Quality and Appropriateness of Care

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A))**

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards

7.1.2. ☒ Performance measurement

7.1.3. ☒ Information strategies

7.1.4. ☒ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. **(2102(a)(7)(B))**

Due to the interrelated nature of Georgia's methods for assuring quality and access, the discussion for part 7.1 and 7.2 are combined below.

Georgia will assure the quality and appropriateness of care provided to Georgia CHIP enrollees using quality standards, performance measurement, information strategies, and quality improvement strategies. DMA has internal information systems that will produce much of the needed data, and additional information will be required through provider contracts.

Our main strategy will be to measure provider performance in achieving access and quality goals, as described below and in Section 9, and feed back the data to providers to encourage improvement. We believe many of the measures described below will point to activities providers and health plans could undertake to improve the organization and delivery of services to help meet the objectives. After the first year of data is available, results from the evaluation may also be used in contracting with health plans and providers to specify quality improvement activities.

Quality Standards

We will determine that health plans and providers meet standards of quality and access already set for the Georgia Better Health Care Program. These are:

Section 8. Cost Sharing and Payment (section 2103(e))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. ☐ YES

8.1.2. ☐ NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income: (Section 2103(e)(1)(A))

8.2.1. Premiums:

- None for children below age 6;
- For children age 6 and above - $7.50 per month for 1 child
- For children age 6 and above - $15.00 per month for 2 or more children

8.2.2. Deductibles: None

8.2.3. Coinsurance: None

8.2.4. Other: None

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income:

The public will be notified of the cost-sharing through premiums for children age 6 and above through the products and materials used in the marketing and public awareness campaigns and used by the RSM outreach workers. They may also be notified through schools, community based organizations or providers who have applications and information regarding the program. They may also be informed by calling the toll-free number for the program, maintained by the TPA. If an application is received by the TPA without a premium and the child(ren) are determined to be eligible for Georgia CHIP, the applicant will be notified by phone or by letter of any premium that must be remitted for the child(ren) to be enrolled.

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its pian (Section 2103(e))

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (section 2103(e)(1)(B))

8.4.2. ☒ **No** cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2))**

8.4.3. ☒ **No** child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

8.4.4. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4))**

8.4.5. ☒ **No** premiums or cost-sharing will be used toward state matching requirements. **(Section 2105(c)(5)**

8.4.6. ☒ **No** funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.
(Section 2105(c)(6)(A))

8.4.7. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1,1997. *(section* **2105(d)(1))**

8.4.8. ☒ **No** funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B))**

8.4.9. ☒ **No** funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above).
(Section 2105)(c)(7)(A))

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed **5** percent of such family's annual income for the year involved:
(Section 2103(e)(3)(B))

The maximum a family could have to pay is $180 annually. This is the maximum family premium of **$15** times 12 months. **Since** there are no deductibles, coinsurance, copayments or other cost-sharing methods, the annual aggregate cost-sharing is the maximum family premium annually. In order for $180 to exceed 5 percent of a family's annual income, the family's annual income would have to be below $3,600. **Uninsured** children in a family with annual income below $3,600 would be eligible for Medicaid rather than Georgia ***CHIP,*** if they met the other eligibility criteria in addition to income criteria. Therefore, with such a low cost-sharing requirement, Georgia will easily ensure that the aggregate cost-sharing for a family never exceeds 5 percent of a family's annual income.

8.6 The state assures that, with respect to pre-existing medical conditions, one of the following **two** statements applies to its plan:

8.6.1. ☐ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section **2102(b)(1)(B)(ii)); OR**

8.6.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section **6.3.2.** of the template). Preexisting medical conditions are permitted to the extent allowed by HIPAA/ERISA (section **2109(a)(1),(2)).** Please describe:

Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2))

The six strategic objectives of Georgia CHIP are to:

1. Increase insurance coverage among Georgia's low income children
2. Increase the percentage of low-income children with a regular source of care.
3. Promote utilization of Health Check (EPSDT) services.
4. Decrease unnecessary use of emergency departments for non-emergency services.
5. Minimize preventable hospitalizations.
6. Promote the appropriate use of health care services by children with asthma (as defined by national standards).

To achieve these objectives, we intend to measure performance, as described below, and feed back the data to providers and health plans. We believe many of the measures described below will point to activities providers and health plans could undertake to improve the organization and delivery of services to help meet the objectives. Through health plan contracting, we will encourage improvement. After the first year of data is available, results from the evaluation may also be used in contracting with health plans and providers.

For objectives 2-6, we will compare the experience of Georgia ***CHIP*** to the experience of Georgia Better Health Care, which enrolls most Medicaid children.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3))

Objective 1: Increase insurance coverage of Georgia's low-income children.

Performance goals:

1.1 By the end of the second year, enroll 60 percent of uninsured, non Medicaid-eligible children with family income below 200 percent of poverty in the new program (approximately 62,000 children).

Measure: Percent of eligible children enrolled.

2.2 Employ marketing and outreach techniques that encourage parents of eligible, low-income children to enroll their children in Georgia CHIP.

Measure: Through survey of new enrollees, learn what motivated enrollment and apply to further marketing and outreach. Survey providers and community-based organizations about outreach and enrollment opportunities and barriers.

Objective 2: Increase the percentage of low-income children with a regular source of care.

Performance goals:
2.1 Over time, decrease the percent of children matched to a PCP through auto assignment.
Measure: Percent of children who selected PCP or HMO on enrollment.
2.2 Encourage use of PCP through health plan policies and education.
Measure: Percent of children who see the same provider for at least **75%** of their visits.

2.3 Maximize the number of enrollees who stay with their PCP for 12 months.
Measure: Percent of enrollees who stay with their PCP one year. We will survey enrollees about their satisfaction with their PCP and their reason for switching.

Objective 3: Promote utilization of Health Check (EPSDT) services to achieve targets set by the Health Care Financing Administration and GBHC. These are 80% for screening and 90% for immunizations.

Performance goals:
3.1 Assess how many children receive recommended well-visits and screenings.
Measure: Percent of enrolled children receiving each screening on or about the recommended schedule.

3.2 Assess how many children receive immunizations.
Measure: Percent of enrolled children receiving each immunization on or about the recommended schedule.

3.3 Increase provider and patient compliance with use of primary and preventive services by feeding back information to providers and health plans about their rates of screening for the enrolled population.
Measure: Percent of PCP panels with improved screening rates in subsequent years.

Objective 4: Decrease unnecessary use of emergency departments for non-emergency services. A non-emergency service is one that does not meet the prudent layperson definition of emergency.

Performance goals:
4.1 Reduce the number of ED visits for non-emergency services.
Measure: Rate of non-emergency ED visits per year for the population enrolled.
Measure: Number of repeat ED visits by the **same** child and by the same family.

4.2 Identify providers with a high rate of referral to the emergency department and provide data on ED utilization.
Measure: Rate of ED visits per 100 patients.

4.3 Examine the rate of authorized referrals by provider to assess whether or not patients are

gaining access to primary care.
Measure: Rate of ED referral by provider.
Measure: Rate of ED referral by provider for the same child for the same condition.

Objective 5: Reduce preventable hospitalizations.

Performance goals:
5.1 Reduce preventable hospitalizations in the second year of the program.
Measure: Number of preventable hospitalizations, based on an existing screening methodology.

5.2 Provide data to providers on preventable hospitalizations among patient panel to encourage improvement in care management.
Measure: Percent of PCPs showing improvement in preventable hospitalization rates in subsequent years.

Objective 6: Promote the appropriate use of health care services by children with asthma (as defined by standards of the National Heart Lung and Blood Institute of the National Institutes of Health).

Performance goals:
6.1 Assess the number of children whose asthma is managed through appropriate outpatient care.
Measure: Percent of children seeing PCP within two weeks of ER or hospital visit.
Measure: Percent of children receiving drug regimen consistent with national guidelines.
Measure: Percent of children for whom appropriate asthma management tools (such as nebulizers, spacers, and mattress bags, etc.) are prescribed.
Measure: Percent of children and parents receiving education.
Measure: Percent of parents responding to a survey who say they are reasonably confident they know how to care for their child with asthma.

6.2 Provide data to PCPs and health plans about performance on asthma care measures so that practices can be modified and appropriate educational materials for patients developed.
Measure: Percent of PCPs whose performance on above indicators improves in subsequent years.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B))

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☒ The reduction in the percentage of uninsured children.

9.3.3. ☒ The increase in the percentage of children with a usual source of care.

9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. ☒ Immunizations
- 9.3.7.2. ☒ Well child care
- 9.3.7.3. ☒ Adolescent well visits
- 9.3.7.4. ☒ Satisfaction with care
- 9.3.7.5. ☒ Mental health
- 9.3.7.6. ☒ Dental care
- 9.3.7.7. ☐ Other, please list: _____

9.3.8. ☐ Performance measures for special targeted populations.

The Georgia Health Policy Center (GHPC), part of Georgia State University's School of Policy Studies, will evaluate Georgia CHIP on behalf of DMA. Data sources will include enrollment, encounter, and family survey data for Georgia CHIP enrollees. Data will be collected at baseline, for all variables for which it is feasible, and at yearly intervals. The GHPC will also make comparisons between the various health plans enrolling Georgia CHIP children to understand the relationship between plan type and success in achieving Georgia ***CHIP*** objectives. For most measures, additional benchmark data will come from Georgia Better Health Care and an existing database comprised of privately insured individuals in Georgia.

The GHPC will request that enrollment and disenrollment data be submitted quarterly. Information about the reasons families disenroll will be collected through personal interviews with a sample of disenrolled families. To track the target population who do not enroll in Georgia CHIP, we will use the Current Population Survey. The CPS will also be used to track private sector insurance and assess whether crowd out is occurring.

DMA convened a workgroup that has provided technical assistance to the GHPC for preparation of this evaluation plan. The workgroup included staff fiom Georgia Better Health Care, Maternal and Infant Health, systems, quality assurance, and data analysis.

9.4. ☒ **The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires.** (Section 2107(b)(1))

9.5. ☒ **The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports.** (Section 2107(b)(2))

The GHPC will complete the required annual assessments and reports, as well as the evaluation due to HCFA on March 31,2000. Data available in time for a March, 2000 report will cover only a small portion of the children we intend to enroll in Georgia CHIP. Process data will be more useful at that point than outcomes, though we will report on as many of the measures as possible. Our assessment will emphasize the following topics:

Insurance Status of Children

GHPC may conduct a phone survey on a biennial basis to assess insurance status, characteristics of those without health insurance (including eligibility for Georgia CHIP), and access to health care. (Decision to be based on the satisfactory resolution of sampling issues in a survey conducted this winter.) Comparisons will be made to the Georgia ***CHIP*** enrollment data. The Current Population Survey will be used to supplement these data, or in place of the data if the survey is not done.

GHPC will compare insurance status to program characteristics to assess how the design or implementation of the program might relate to the success of the program in enrolling the target population. For example, has the program reached children in rural areas as well as urban areas? Does insurance increase the likelihood that children in more remote parts of the state get immunizations on time? Have premiums been a barrier to enrollment?

Program Design

GHPC will evaluate the major program characteristics (e.g., eligibility criteria, covered services, administrator, participating providers, provider payments, outreach and marketing, enrollment, etc.) to understand how the program has worked. In order to do this, they will conduct interviews with program administrators and review program materials. The quality assurance activities described in section seven will be an important source of information. If problem areas are identified, GHPC will conduct more in-depth analysis.

Outreach and marketing are especially important to the success of the program. It is often difficult to enroll people eligible for public programs because they do not know they are eligible, they want to avoid the stigma of a public program, or the enrollment process is so cumbersome that they cannot complete it. GHPC will evaluate which methods of outreach and enrollment are successful in enrolling

hard to reach populations in order to target future outreach efforts appropriately. They will also track applications that do not result in enrollment in order to understand and resolve any unintended barriers.

Impact on Access to Care

As part of Section 9.2, GHPC will be measuring access to recommended primary and preventive services, having a regular source of care, emergency department use, preventable hospitalizations, and appropriateness of care for children with asthma. In the evaluation, they will compare the data on Georgia CHIP enrollees to data from Georgia Better Health Care enrollees and privately insured children (available through an existing private sector database). They will look for significant differences, and assess the extent to which the program may account for such differences. At the same time, they will assess the impact of demographic differences on variation in utilization among these three groups.

Coordination with Other Federal and State Programs

An important goal of Georgia CHIP is coordination with other state programs that serve low-income children, such as Title V, the maternal and child health block grant, WIC, and others. GHPC will describe the relationship between Georgia CHIP and these other public programs that serve the same target population or are relevant in terms of coordination. They will highlight where the programs overlap or are complementary. Data will be collected for this part of the analysis through semi-structured interviews with key managers of the programs and a review of program records on applications, eligibility determinations, and enrollment.

Changes in the State Affecting Quality or Access

GHPC will use data from the phone survey and the CPS to measure the level of private health insurance coverage for children in the state, and characteristics of families with privately insured children. They will assess whether private insurance coverage declines in response to the increased availability of public insurance.

They will also look for other changes and trends in the state that may affect the provision of health insurance and health care to children. For example, they will review data filed with the Division of Insurance to see if fewer private sector insurance policies are covering children. Data from the household survey will be used to look for effects from recent Federal legislation, such as welfare reform and the Health Insurance Portability and Accountability Act, to separate out these trends from the impact of Georgia CHIP.

Program Satisfaction

Finally, the GHPC will assess satisfaction with the program by holding focus groups of parents of enrollees to learn about how the program is meeting their needs, any barriers they face to using the

program, and how the program might be improved. We will also hold focus groups of non-enrolled eligible families to find out why they have not enrolled, as that may lead to program improvements as well. We are particularly interested in the impact of premiums on non-enrollment, and will explore this issue in the focus groups.

9.6. ☐ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3))

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XM: (Section 2107(e))

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. ☒ Section 1115 (relating to waiver authority)

9.8.5. ☐ Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI

9.8.6. ☒ Section 1124 (relating to disclosure of ownership and related information)

9.8.7. ☐ Section 1126 (relating to disclosure of information about certain convicted individuals)

9.8.8. ☒ Section 1128A (relating to civil monetary penalties)

9.8.9. ☒ Section 1128B(d) (relating to criminal penalties for certain additional charges)

9.8.10. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c))

Initial Public Involvement

In 1996, the Georgia Coalition for Health was asked by the Governor to examine approaches for reforming Medicaid in Georgia. The Coalition sponsored extensive research on the views of the stakeholders in the state's Medicaid system – healthcare providers, Medicaid beneficiaries and Georgia citizens. Three separate but complementary processes—focus groups, community forums and community dialogues—offered the opportunity for about 6,000 Georgians to express their views.

This unique process of obtaining stakeholder input served as a foundation for convening people with varied perspectives and expectations, raising awareness about those perspectives, identifying areas of agreement and disagreement, and working together to find solutions to difficult problems.

Georgia Health Decisions was commissioned by the Coalition to conduct research to learn what changes citizens would support in the state's Medicaid program. Citizen input was gathered through focus groups in all areas of the state, with almost 500 people participating. Focus group participants were randomly chosen to represent all socio-economic segments of Georgia's population. Eleven focus groups were composed of Medicaid beneficiaries, and six others were made up of healthcare providers. Further, Georgia Health Decisions conducted **200** open community forums throughout the state in which 5,000 Georgians had the opportunity to express their concerns about Medicaid reform.

In addition, the Georgia Health Policy Center engaged 14 communities across Georgia in Medicaid community dialogues. The objectives of the dialogues were to ensure a process for obtaining input fiom Medicaid consumers and health care providers around the state; to clarify an understanding of the issues related to Medicaid reform and the ramifications of those issues; and, to identify examples of system disincentives that could be corrected by changes in policy.

The consumers and advocates participating in the dialogues were identified by a coalition of consumers and advocates incorporated under the name Healthcare for a Lifetime. This group represents the four primary populations that receive Medicaid: low income Mothers and children, older people, people with physical disabilities, and people with mental retardation, mental illness, or those with substance abuse problems. The providers were selected by the Healthcare Providers Council and included representation fiom hospitals, physicians, nursing, dentistry, nursing homes, home health, pharmacy, public health, community health and others. County Commissioners as well as members of the legislature were also invited to attend. Overall, **443** consumers and advocates and **234** providers participated for a total of 677 statewide participants. The meetings were open to the public and at every Dialogue there were observers who did not participate in the discussions yet had the advantage of moving among groups and hearing all four conversations.

These statewide, public conversations on Medicaid contributed to dispelling barriers between consumers and providers; the process also indicated where consumers, advocates and providers stand on major issues and where they are willing to negotiate. The main themes identified through the process are summarized below. These themes served as a reference and defining force for developing general Medicaid reform recommendations and many are reflected in Georgia's proposal for

implementing the Title XXI program.

Citizens

The citizens, both Medicaid beneficiaries and members of the general public, expressed a wide variety of views, but agreed on a few basic themes.

- Vulnerable people should be protected, Citizens generally believe in the concept of a health care safety net and are willing to pay taxes to provide health care to people who need help.

- Only truly needy individuals should qualify for Medicaid. Citizens want to make sure that eligibility is strictly defined and enforced to stop abuse.

- Nothing should be free. Citizens want all adult Medicaid beneficiaries to make some financial contribution toward their care, generally favoring a sliding scale based on income. They believe welfare recipients should work. They also want to make sure that families contribute to the cost of caring for disabled children and, perhaps, elderly parents.

- Health care should be accessible to all Georgians. Citizens worry about rising health care costs and their own ability to get affordable coverage, even if they now have health benefits, they worry about losing them. People are also concerned about the uninsured and would like to broaden Medicaid reform to also offer affordable coverage for this group.

Medicaid Beneficiaries

In the community dialogues, Medicaid beneficiaries generally shared the opinions of the general population, as described above, but also expressed some specific concerns.

- Medicaid costs should not be cut by reducing eligibility, since not enough truly needy people are covered even today.

- There should be no stigma attached to receiving Medicaid, and any managed care plans used in the program should serve both Medicaid beneficiaries and non-Medicaid patients.

- Prevention and education should be integral components of any benefits package.

Providers

In addition to participating in the focus groups and community dialogues, many health care providers were interviewed for a separate study as part of a detailed analysis of the current health care delivery system in Georgia. Key findings from that research are summarized below:

- The delivery system is in rapid transition. Organized health plans are widespread in the state, displacing traditional fee-for-service reimbursement plans. Hospitals and other providers are restructuring, merging and forming networks to compete with insurer-sponsored managed care organizations.

- A quick-budget-fix approach to Medicaid reform could harm public health and actually raise costs in the long run. Providers would support a serious, well-reasoned reform effort, developed through a fair process that listens to providers' concerns, and includes realistic transition periods.

- Any reform plan should include performance standards, outcome measures, accountability, competition, and choice (for both beneficiaries and providers). Providers should be able to at least break even financially if they participate in Medicaid, and a small profit would be appropriate as recompense for taking risk.

- Providers who have traditionally served the Medicaid population with demonstrated quality should be included in a managed care or any other delivery system.

About six months after this public input process was completed, the Georgia Coalition for Health Board, concerned about the effects of Medicaid reform on uninsured children, asked the Health Policy Center to study mechanisms for providing coverage to this target population. In response to this charge, the Policy Center applied for (and was subsequently awarded) a Robert Wood Johnson Foundation grant to replicate the Florida Healthy Kids program. The Coalition also allocated funding to the Center to conduct preliminary planning activities so that Georgia could position itself for implementing the Healthy Kids program as well as the impending federal children's health insurance legislation.

From May through December 1997, the Center established several advisory committees with representation from key agencies and organizations around the state. (It should also be noted that, according to the reviewers from the Robert Wood Johnson Foundation, one of the most impressive components of the initial grant and the subsequent planning efforts was the inclusive process for obtaining input from affected stakeholders into the design of the program.) The committee structure included a primary broad-based Children's Health Insurance Advisory Committee and four subcommittees, each governed by specific charges that addressed the major programmatic issues of benefits package, eligibility criteria, program design, and local collaboration. There were a total of 40 individuals on the full advisory committee and four subcommittees, however, these meetings were open to and attended by several additional visitors and observers. There were about 25 meetings of the full advisory group and the subcommittees between April and December. Membership on these groups was comprised of representatives from the following agencies and organizations:

- Association of County Commissioners of Georgia
- Augusta/Richmond County Community Partnership
- Caring Program for Children
- Chatham-Savannah Youth Futures Authority

- Child Psychologist
- Childrens Hospitals (Egleston, Hughes-Spalding, Scottish Rite)
- Council on Maternal and Infant Health
- Department of Education
- Department of Medical Assistance (Division of Maternal and Child Health, Eligibility and Quality Control, and Strategic Planning)
- Division of Family and Children Services
- Division of Mental Health/Mental Retardation/Substance Abuse
- Division of Public Health (Division Director, Child and Adolescent Health Unit, Gwinnett County Health District, DeKalb County Board of Health)
- Georgia Academy of Family Physicians
- Georgia Association for Primary Health Care
- Georgia Chapter/American Academy of Pediatrics
- Georgia Dental Association
- Georgia Partnership for Caring
- Georgia Policy Council for Children and Families
- Georgians for Children
- Governor's Office of Planning and Budget
- Healthy Mothers, Healthy Babies Coalition of Georgia
- March of Dimes
- Office of the Commissioner of Insurance
- Tanner Medical Center
- The Family Connection
- United Healthcare
- Wachovia Bank of Georgia Compensation and Benefits Branch
- West Georgia Medical Center

In addition, separate group meetings were held with child advocates, health plan representatives, and public health district officers to explain the program and obtain input about specific components of the program design for CHIP. During December, January, February and March, several legislative hearings were held in both the Senate and House of Representatives. The hearings focused on the Governor's proposal for implementing Title XXI in Georgia. At these hearings, testimony was provided by child advocates, state agencies, pediatricians and other health care providers.

Public Notice

At the regular meeting of the Board of Medical Assistance on April 8, 1998, DMA staff provided a public briefing for the Board on the status of the Georgia CHIP planning process. Again, at the regular meeting of the Board on May 13, 1998, the DMA will present detailed information to the Board and the public about the proposed Georgia CHIP, and give opportunity for public comment. The May meeting has been extensively publicized with a notice mailed to a large mailing list of stakeholders in Medicaid and CHIP, in addition to regularly published meeting notices.

Ongoing Public Involvement

The Medical Assistance Study Committee was created by the House Appropriations Committee in June, 1997. It was charged with conducting a comprehensive study of the Medicaid system in Georgia. The rationale was for a core group of people on the Appropriations Committee to learn as much as possible about the complexities of the budget item known as Medicaid .

Identifying problems and finding opportunities in Georgia's Medicaid system were main challenges of the committee. To meet these, a series of hearings were conducted around the state, sixteen (16) in all. They began in the summer and ended in the fall of 1997. Georgia is comprised of one hundred fifty-nine counties, urban and rural. Input was gathered from big metropolitan areas, such as Atlanta and Savannah, and small rural areas, such as Greensboro and Moultrie, to name a few. Providers and their respective associations, professional health care associations, community groups, patient advocates, Medicaid recipients, and interested citizens were invited to share their concerns with the committee.

Through the hearings, the Committee identified significant findings in fifteen different areas ranging fiom reimbursement to providers to health care for those with disabilities. Along with the findings, recommendations were made to DMA. A copy of the Committee's report is on file with DMA. Members of the Committee took lead roles in drafting the Georgia *CHIP* legislation. The Committee will continue to meet at intervals and review the progress of CHIP implementation as well as the ongoing Medicaid program.

9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (section 2107(d))

For Federal Fiscal Year 1999

1. Benefit Expenditures	$62,950,371
2. Administrative Expenditures	$6,994,486
TOTAL	$69,944,857
3. Federal Share	$47,100,658
4. State Share (all General Fund)	$17,785,219
5. Premiums	$ 5,058,980
TOTAL	$69,944,857

Explanation of Expenditures

1. Benefit Expenditures
This line item reflects the reimbursements to providers for the provision of health care services to the CHIP enrollees.

2. Administrative Expenditures
This line item includes costs associated with enrolling children in the ***CHIP*** program.

Explanation of Revenues

3. Federal Share
This line item reflects a portion of funds which have been allocated to Georgia under Title XXI.

4. State Share
This line item reflects a portion of the funds which have been allocated specifically to the Georgia Department of Medical Assistance by the Georgia General Assembly.

5. Premiums
This line item reflects cost sharing funds that will be collected from eligible families In accordance with the description in Section 8 of this Plan.

Section **10.** Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: *(section* **2108(a)(1),(2))**

10.1.1. ☒ The progress made in reducing the nqmber of uncovered low-income children and report to the Secretary by January **1** following the end of the fiscal year on the result of the assessment, and

10.1.2. ☐ Report to the Secretary, January **1** following the end of the fiscal year, on the result of the assessment.

Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

Attributes of Population	Number of Children with Creditable Coverage XIX OTHER CHIP	Number of Children without Creditable Coverage	TOTAL
Income Level:			
< 100%			
≤ 133%			
≤ 185%			
≤ 200%			
> 200%			
Age			
0 - 1			
1 - 5			
6 - 12			
13 - 18			
Race and Ethnicity			
American Indian or Alaskan Native			
Asian or Pacific Islander			
Black, not of Hispanic origin			
Hispanic			
White, not of Hispanic origin			
Location			
MSA			
Non-MSA			

Proposed Effective Date: 07/01/98

10.2. ☒ State Evaluations. The state assures that by March **31,2000** it will submit to the Secretary an evaluation of each of the items described and listed below: (Section **2108(b)(A)-(H))**

10.2.1. ☐ An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.

10.2.2. ☐ A description and analysis of the effectiveness of elements of the state plan, including:

10.2.2.1. ☒ The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;

10.2.2.2. ☒ The quality of health coverage provided including the types of benefits provided;

10.2.2.3. ☒ The amount and level (including payment of part or all of any premium) of assistance provided by the state;

10.2.2.4. ☒ The service area of the state plan;

10.2.2.5. ☒ The time limits for coverage of a child under the state plan;

10.2.2.6. ☒ The state's choice of health benefits coverage and other methods used for providing child health assistance, and

10.2.2.7. ☐ The sources of non-Federal funding used in the state plan.

10.2.3. ☐ An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.

10.2.4. ☒ A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.

10.2.5. ☒ An analysis of changes and trends in the state that affect the

provision of accessible, affordable, quality health insurance and health care to children.

10.2.6. ☐ A description of any plans the state has for improving the availability of health insurance and health care for children.

10.2.7. ☐ Recommendations for improving the program under this Title.

10.2.8. ☒ Any other matters the state and the Secretary consider appropriate.

10.3. ☒ The state assures it will comply with future reporting requirements as they are developed.

10.4. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

ATTACHMENT 1

Proposed Effective Date: 07/01/98

1. Walker 22nd 2. Middleton 50th 3. Thomas 10th

SB 410 98 SB410/AP

SENATE BILL 410

By: Senators Walker of the 22nd, Middleton of the 50th, Thomas of the 10th and others

A BILL TO BE ENTITLED
AN ACT

To amend Chapter 5 of Title 49 of the Official Code of Georgia Annotated, relating to programs and protection for children and youth, so as to create the "Peachcare for Kids Act"; to provide for a short title, legislative findings, and definitions; to provide for the creation of a health care coverage program for certain children and for its administration and funding; to provide for eligibility and coverage; to provide for copayments and premiums; to provide for outreach, applications, and enrollment; to provide for health care provider enrollment and reimbursement; to provide for plan submission and action to obtain federal approval; to provide for submissions of copies of the plan; to provide for reports and agency cooperation; to provide for certain agency and other contracts; to provide for separate budget units and appropriations; to provide for an effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1

Chapter 5 of Title 49 of the Official Code of Georgia Annotated, relating to programs and protection for children and youth, is amended by adding at the end a new article to read as follows:

"ARTICLE 13

Proposed Effective Date: 07/01/98

49-5-270.

This article shall be known and may be cited as the 'Peachcare for Kids Act.'

49-5-271.

The General Assembly finds and declares that a large proportion of school-aged children in Georgia do not currently have access to adequate medical treatment and, further, that this lack of access can hinder a child's ability to reach his or her full physical and educational

potential. The General Assembly further finds that federal funding made available to the states under Title XXI of the federal Social Security Act may be used to administer programs to provide such coverage. The General Assembly further finds the provision of adequate medical coverage for this population to be in the public interest and further declares the establishment of the program pursuant to this article to be a desirable and economical means of increasing access to such medical coverage.

49-5-272.

As used in this article, the term:

(1) 'Department' means the Department of Medical Assistance.

(2) 'Federal law' means Title XXI of the federal Social Security Act.

(3) 'Medicaid' means medical assistance provided under Article 7 of Chapter **4** of this title, the 'Georgia Medical Assistance Act of **1977.'**

(4) 'Peachcare' or 'program' means the Peachcare for

Kids Program created by

49-5-273.

(a) There is created the PeachCare for Kids Program to provide health **care** benefits for chiidren in families with income below 200 percent of the federal poverty level. Children from birth through **18** years of age in families with family incomes below **200** percent of the federal poverty level and who are not eligible for medical assistance under Medicaid shall be eligible for the program, to be administered by the department pursuant to federal law and subject to availability of fbnding.

(b) No entitlement to benefits for the children covered under the program or this article shall be created by the program, nor shall this article or any rules or regulations adopted pursuant to this article be interpreted to entitle any person to receive any health services or insurance available under this program. The program shall be established subject to the availability of funds specifically appropriated by the General Assembly for this purpose and federal matching funds as set forth in federal law. The department shall operate the program

consistent with administrative efficiency and the best interests of children.

(c) The program shall offer substantially the same health care services available to children under Georgia's Medicaid plan, but coverage for such services shall not be provided by an expansion of eligibility for medical assistance under Medicaid. However, the program shall exclude nonemergency transportation and targeted case management services. The department shall utilize appropriate medical management and utilization control

procedures necessary to manage care effectively and shall prospectively limit enrollment in the program and modify the health care services benefits when the department has reason to believe the cost of such enrollment or services may exceed the availability of funding.

(d) The department may require copayments for services consistent with federal law; provided, however, that no copayment shall be charged for preventive services and no copayments or premiums shall be charged for any child under six years of age. Preventive services include but are not limited to medically necessary maintenance medication and monitoring for chronic conditions such as asthma and diabetes.

(e) The department shall require payment of premiums for participation in the program. The premiums shall not exceed the amounts permitted under Section 1916(b)(1) of the Social Security Act or federal law.

(f) The department may provide for presumptive eligibility for all applicant children as allowed by federal law and in a manner consistent with the provisions of this article.

(g) The department shall provide for outreach for the purpose of enrolling children in the program. Applications shall be accepted by mail or in person. All necessary and appropriate steps shall be taken to achieve administrative cost efficiency, reduce administrative barriers to application for and receipt of services under the program, and ensure that enrollment in the program does not substitute for coverage under a group health insurance plan.

(h) Any health care provider who is enrolled in the Medicaid program shall be deemed to be enrolled in the program.

(i) The department shall file a Title XXI plan to carry out the program with the United States Department of Health and Human Services Health Care Financing Administration by June 1, 1998. The department shall have the authority and flexibility to make such decisions as are necessary to secure approval of that plan consistent with this article. The department shall provide a copy of the plan to the General Assembly. The department shall operate this program consistent with federal law.

(j) The department shall publish an annual report, copies of which shall be provided to the Governor and the General Assembly setting forth the number of participants in the program, the health services provided, the amount of money paid to providers, and other pertinent information with respect to the administration of the program.

(k) All state agencies shall cooperate with the department and its designated agents by providing requested information to assist in the administration of the program.

(l) The department, through the Department of Administrative Services or any other appropriate entity, may contract for any or all of the following: the collection of premiums, processing of applications, outreach, data services, and evaluation, if such contracting achieves administrative or service cost efficiency. The department, and other state agencies as appropriate, shall provide necessary information to any entity which has contracted with the department for services related to the administration of the program.

(m) Nothing in this article shall be interpreted in a manner so as to preclude the department from contracting with licensed health maintenance organizations (HMO) or provider sponsored health care corporations (PSHCC) for coverage of program services and eligible children in a metropolitan statistical area; provided, however, that such contracts shall require payment of premiums and copayments in a manner consistent with this article. The department may not require enrollment in a health

maintenance organization (HMO) or provider sponsored health care corporation **(PSHCC)** as a condition of receiving coverage under the program.

(n) There shall be created a separate budget unit 'C' and a separate appropriation in the department for the purpose of carrying out the provisions of this article."

SECTION 2

This Act shall become effective upon its approval by the Governor or upon its becoming law without such approval.

SECTION 3

All laws and parts of laws in conflict with this Act are repealed.

ATTACHMENT 2

Proposed Effective Date: 07/0 1/98

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
Family and Children's Health Programs Group
Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, Maryland 21244-1850

FEB - 9 1998

Nancy Ellery
Administrator
Department of Public Health and
Human Services
Health Policy and Services Division
Cogswell Building
1400 Broadway
P.O. Box 202951
Helena, Montana 59620-2951

Dear Ms. Ellery:

This letter is in response to your request for guidance, dated December 19, 1997, on whether Montana children covered under the Caring Program are eligible for the Child Health Insurance Program (CHIP).

As you stated in your letter and during a subsequent phone conversation with my staff, Montana's Caring Program does not meet the definition of "creditable health coverage" as defined under Section 2701(c) of the Public Health Service Act (42 U.S.C.300gg(c) and referred to in Section 2110(c)(2) of Title XXI. As such, these children would be considered uninsured and would be eligible for Title XXI, provided they meet the other eligibility requirements.

Thank you for your inquiry. We look forward to working with you as you develop your Title XXI program.

Sincerely,

Sidney Trieger
Director

Proposed Effective Date: 07/01/98

Caring Program for Children℠

March 16, 1998

Ms. Mary Ann Phillips
Georgia Health Policy Center
Georgia State University, University Plaza
Atlanta, Georgia 30303-3083

Dear Mary Ann:

I appreciate the opportunity to offer a written statement regarding the Caring Program for Children charitable benefits and the new SCHIP program in Georgia. As we discussed by phone, the Caring Program does not offer "credible coverage" for the children participating. The limited preventive and primary health services that children may access are contingent upon community donations; the Caring Program is not a regulated insurance product and functions solely on donations to sponsor needy, uninsured children. No premiums are paid by families that participate.

As the National Coordinating Council of Caring Programs works to craft a general agreement with HICFA regarding the "crowd out" issue, I pledge to keep you informed on any correspondence we receive from HICFA offices to further verify that the Georgia Caring Program is not true, credible health insurance and that children currently accessing limited medical care via our charity are eligible for SCHIP programs. In the meantime, I offer the Caring Programs of Alabama and Montana as precedents on this issue. Both programs are structured similarly to the Georgia Caring Program as charitable organizations; HICFA has determined that children enrolled in the Alabama Caring Program are in fact eligible for the new Alabama CHIP program; the same applies to Montana, and I have attached a copy of the correspondence from HICFA to the Montana Caring Program outlining the fact that the Caring Program there is also not credible and true coverage.

If I may offer any additional information, please do not hesitate to call upon me. I look forward to collaborating with you and the team at State Merit to effectively transition our children to the new CHIP program.

Sincerely,

Carolyn A. Polakowski
Executive Director

encl.

GEORGIA CARING PROGRAM FOR CHILDREN FOUNDATION, INC.* BLUE CROSS AND BLUE SHIELD OF GEORGIA*
*INDEPENDENT LICENSEES OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

Proposed Effective Date: 07/01/98

ATTACHMENT 3

Proposed Effective Date: 07/01/98

Family Size	Federal Poverty Level Guidelines for RSM and CHIP				
	(100%)	(133%)	(150%)	(185%)	(200%)
1	671	893	1007	1242	1342
2	905	1203	1357	1673	1809
3	1138	1513	1707	2105	2275
4	1371	1824	2057	2537	2742
5	1605	2134	2407	2968	3209
6	1838	2444	2757	3400	3675
7	2071	2755	3107	3832	4142
8	2305	3065	3457	4263	4609

For each additional person over budget group size 8:

RSM (100% FPL) add $234
RSM (133% FPL) add $311
RSM (150% FPL) add $350
TMA (185% FPL) add $432
***CHIP* (200% FPL) add $467**

ATTACHMENT 4

Proposed Effective Date: 07/01/98

First M.I. Last Name	Maiden Name	Phone Numbers
		Day: Eve:
Street Address City/St./Zip		Mailing Address City/St./Zip

Name						Citizen Y/N	Health Insura Y/N

INCOME	Y/N	Amt. Before Deductions	How Often?	Name of Person Receiving?
Current Job (Wages, Earnings & Salary) Employer's Name				
Current Job (Wages, Earnings & Salary) Employer's Name				
Social Security Income				
SSI				
Workers Compensation				
Pensions or Retirement Benefits				
Child Support				
Contributions				
Uneinployment Benefits				
Other Income Specify:				

I want to apply for Medicaid for any children not eligible for Peachcare: Yes _____ No _____

Proposed Effective Date: 07/01/98

Have any of the children you are applying for lost health insurance coverage in the past three months? Yes ___ No _____

If yes, explain _____

_____

Do you pay childcare expenses? If yes, how much? _____ How Often? _____

For which children?: _____

_____

_____

Do you have **any** unpaid medical bills from the past three. months? Yes _____ No _____

I understand that I will be. asked to choose. to receive my medical **care** through an HMO or Georgia Better Health Care.
I would like to choose _____ now. (You may name your current doctor if he/she participates in Georgia Better Health Care) If you don't have a current doctor you wish to select, you may make the selection later).

Wage and salary information obtained on me by the Department of Labor may be disclosed to a non-governmental third party administrator to determine my eligibility: Yes _____ No _____

I certify that the information I have given is true and correct to the best of my knowledge. I understand that this information I have supplied **will be.** verified **to** determine my eligibility for the ***CHIP*** program. I understand that for CHIP I must report any changes in my circumstances within ten (10) days of becoming aware of the change. I **have read or had read to me and understand the information on this form. I agree to apply for a social security number if I do not have one. Yes _ No —.**

_____ _____

Applicant's Signature **Date** **Representative's Signature** **Title**

_____

Date

Premiums for **Peachcare:**	**Amount:**
Children ages 0 - **5** years	$ 0
Children ages 6 - **18** years	**$7.50**
2+Children Ages 6-18 years	$15.00

ATTACHMENT 5

Proposed Effective Date: 07/0 1/98

Summary Comparison of
Georgia ***CHIP***
and
"Benchmark" Plan Benefit Packages

Georgia CHIP (Medicaid "Look-Alike")			Benchmark Plan: BlueChoice (HMO) Health Care		
COVERED BENEFIT	**COPAY**	**BENEFIT MAXIMUMS[1]**	**COVERED BENEFIT**	**COPAY**	**BENEFIT MAXIMUMS[1]**
Inpatient Hospital Services	None	NIA	**Inpatient Hospital Services**	None	N/A
Outpatient Hospital Services	None	N/A	**Outpatient Hospital Services**	None	N/A
Emergency Room Services	None	N/A	**Emergency Room Services**	$50 (waived if admitted)	No coverage for non-emergency use of the emergency room
Inpatuent Mental Health Care	None	Thirty Days per Admission. Physician Services are Limited to 10 Hours per Month for Psychotherapy	**Inpatuent Mental Health Care**	None	30 Days per Calendar Yea?
Inpatient Substance Abuse	None	Thirty Days Per Admission	**Inpatient Substance Abuse**	None	6 Days per Calendar Year

N/A - none applied (other than any requirement imposed under the Title XIX program)

Summary Comparison of Georgia CHIP and "Benchmark" Plan Benefit Packages - ***continued***

[1] **Other** than the limitations related to medical necessity and clinical appropnatemessof services
[2] Inpatient care for the treatment of bulimia, anorexia, or other eating disorders is not covered when provided primarily for behavior modification, diet, weight monitoring and education. ***Also,*** court-ordered services are not covered.

Proposed Effective Date: 07/01/98

Georgia CHIP (Medicaid "Look-Alike")			Benchmark Plan Blue Choice (HMO) Health Care		
COVERED BENEFIT	COPAY	BENEFIT MAXIMUMS	COVERED BENEFIT	COPAY	BENEFIT MAXIMUMS
Outpatient Mental Health Care and Substance Abuse Treatment Community Mental Health Centers (CMHCs)	None	Psychotherapy is limited to 24 Hours per Calendar Year by a Licensed Clinical Psychologist CMHCs are subject to the limitations specified in Department of Human Resource Standards	**Outpatient Mental Health Care and Substance Abuse Treatment**	**$25**	20 Visits per Calendar Year
Physicians Office Services (includesthe comprehensive EPSDT program)	None	Physicians Services are Limited to 12 Hours per Calendar Year for Psychotherapy	**Physicians Office Services** (includes Well-Child Care)	$10	NIA
Physicians Services (within a Hospital/Institutional setting)	None	N/A	**Physicians Services (within a Hospital/Institutional setting)**	None	**NIA**
Physical/Occupational Therapy	None	NIA	**Physical/Occupational Therapy**	None	N/A

N/A - none applied (other than any requirement imposed under the Title XIX program)

Summary Comparison of Georgia CHIP and "Benchmark" Plan Benefit Packages - *continued*

Proposed Effective Date: 07/01/98

Georgia CHIP (Medicaid "Look-Alike")			Benchmark Plan BlueChoice (HMO) HealthCare		
COVERED BENEFIT	COPAY	BENEFIT MAXIMUMS	COVERED BENEFIT	COPAY	BENEFIT MAXIMUMS
Speech Therapy	None	N/A	Speech Therapy	None	30 Visits per Calendar Year[3]
Allergy Shots, Serum & Testing	None	N/A	Allergy Shots, Serum & Testing	$10	NIA
Immunizations	None	N/A	Immunizations	None	N/A[4]
Prescription Drugs: • Generic • Brand Name • Mail Order (90 Day Supply) • Over-the-Counter	 None None Not Avail None	N/A[5]	Prescription Drugs: • Generic • Brand Name • Mail Order (90 Day Supply) • Over-the-Counter	 $ 5 $15 $10 Not Covered	Benefits are not paid for prescriptions written by non-network providers
Home Health Care Services	None	N/A	Home Health Care Services	None	120 Visits Per Calendar Year
Hospice Services	None	N/A	Hospice Services	None	$10,000 Lifetime Maximum
Skilled Nursing Facility[6]	N/A	Not a Covered Service	Skilled Nursing Facility	None	30 Days Per Calendar Year

N/A - none applied (other than any requirement imposed under the Title XIX program)

[3] Speech therapy provided by schools is not a covered benefit

[4] Other than Physicians Office Visit copay (no separate charge).

[5] While Medicaid imposes some prescription limitations for utilization management purposes, those limits may be exceeded for children upon request of a physician

[6] This is actually a benefit for adults. SNFs in the State do not typically accept children.

Summary Comparison of Georgia CHIP and "Benchmark" Plan Benefit Packages - *continued*

Georgia CHIP (Medicaid "Look-Alike")			Benchmark Plan BlueChoice (HMO) HealthCare		
COVERED BENEFIT	COPAY	BENEFIT MACHINES[7]	COVERED BENEFIT	COPAY	BENEFIT MACHINES
Laboratory Services	None	NIA	**Laboratory Services**	None	N/A
Radiology Services	None	**Covered only in the Hospital and Physician Programs**	**Radiology Services**	None	**N/A**
Durable Medical Equipment	None	N/A	**Durable Medical Equipment**	None	Certain Items are Excluded
Orthotics/Prosthetics	None	N/A	**Orthotics/Prosthetics**	None	**Certain Items are Excluded**
Dental Services ▪ **Preventive/ Restorative** • **Oral Surgery**	None	N/A	**Dental Services** • **Preventive/ Restorative** • **Oral Surgery**	N/A N/A	Preventive and Restorative Services are not Covered Benefits. Oral surgery is generally covered only for traumatic injuries, treatmemt of TMJ, or correction of congenital deformities.
Vision Services	None	N/A	**Vision Services**	N/A	Not a Covered Service

N/A - none applied (otber than any requirement imposed under the Title XIX program)

[7] § 10 if a consultation with a radiologist

Summary Comparison of Georgia CHIP and "Benchmark" Plan Benefit Packages - *continued*

Georgia CHIP (Medicaid "Look-Alike")			Benchmark Plan BlueChoice (HMO) HealthCare		
COVERED BENEFIT	**COPAY**	**BENEFIT MAXIMUMS**	**COVERED BENEFIT**	**COPAY**	**BENEFIT MAXIMUMS**
Family Planning	None	NIA	**Family Planning**	$10	Contraceptive Devices (Including Norplant) are Not Covered
Emergency Ambulance	None	N/A	**Emergency Ambulance**	None	N/A
Podiatry	None	N/A	**Podiatry**	None	NIA
Other Provider Services • FQHC • RHC • Nurse Midwife • Nurse Practitioner	None	N/A	**Other Provider Services** • FQHC • RHC • Nurse Midwife • Nurse Practitioner	None	If the physician practicing in an FQHC or RHC is a network provider, benefits are provided as physician services - there is no separate category for these providers.
Maternity Care	None	N/A	**Maternity Care**	$10 **Physician** $0 **Hospital**	NIA

N/A - none applied (other than any requirement imposed under the Title XIX program)

Proposed Effective Date: 07/01/98